Early Psychosis Learning Health Care Network

STATEWIDE COLLOBORATIVE

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Primary Purpose and Qualification as an Innovation Project

The proposed Innovation Project will make a change to an existing practice in the field of mental health by introducing a collaborative Learning Health Care Network (LHCN) to support quality improvements, consumer engagement and provider use of measurement-based care in early psychosis (EP) programs. This LHCN will collect and visualize real-time data at the individual, clinic, county and state levels to inform consumer- and program-level decisions and develop learning opportunities for individuals, staff, programs and administrators, in order to improve consumer outcomes. In addition, this project will include training and technical assistance to EP program providers to help them fully utilize the data in routine clinical care. The associated evaluation will examine the impact of the LHCN on the EP programs, and will quantify the cost of implementation and utilization, in order to support statewide efforts for early identification and treatment of psychosis. This project proposes an innovative approach to state-level learning and real-time outcomes monitoring for consumers, their families, and EP programs. ***Aligning with a primary purpose for an Innovation project as identified by the MHSOAC, this project seeks to increase the quality of services, including measurable outcomes.***

The proposed project meets a variety of unmet needs across the state:

1. Collects and visualizes consumer-level data across a variety of recovery-oriented measures to directly inform day-to-day service provision. Training and technical assistance will be provided to support the ability for EP program providers to use the LHCN data in practice, transforming these services to measurement-based care.
2. Provides immediate access to relevant outcome data for program leadership that can be quickly shared with stakeholders, the county, or the state. Rapid dissemination of program outcomes has historically been a challenge for county-based programs.
3. Provides infrastructure for an EP Learning Collaborative across counties, in which common challenges can be identified and “lessons learned” can be quickly disseminated, creating a network of programs that rapidly learn from and respond to the changing needs of their consumers and communities.
4. Evaluation of the LHCN will provide information on how to incorporate measurement-based care into mental health services and demonstrate impact of the LHCN on the recipients and providers of EP care.

Primary Problem

A number of interventions are effective in reducing psychotic symptoms and promoting functional recovery in first-episode psychosis, including low doses of antipsychotic medication (Sanger et al., 1999), cognitive behaviorally-based psychotherapy (Lecomte et al., 2008; Wang et al., 2003), family education and support (Leavey et al., 2004) and educational and vocational rehabilitation (Nuechterlein et al., 2008). These elements are typically delivered together in a team-based approach in specialized early psychosis (EP) programs (Goldstein & Azrin, 2014). This contrasts with standard care delivered within non-specialized community mental health teams where fewer of these treatment components are typically available, and the components that are available are often delivered across multiple services in a less coordinated approach.

The Prevention and Early Intervention (PEI) component of the Mental Health Services Act (MHSA), coupled with a legislative focus on early psychosis (AB 1315, SB 1004), has led to an expansion of specialized EP programs across California. These programs target individuals early in the course of mental illness, with a goal of preventing mental disorders from becoming severe and disabling. As of 2017, 30 EP programs exist serving consumers across 24 of the 58 Counties of California. However, these programs were started county by county with little collaboration in training or implementation.

As a result, there is significant variation in the EP programs delivered across counties (Niendam et al., 2017), and many programs feel isolated and struggle to get the training and technical assistance needed to keep their EP program flourishing. While there is evidence that EP programs are effective (Kane et al., 2015), it is not clear which components of the EP service model are key to improving particular outcomes. As a result, it is currently unclear to what degree this variation is impacting outcomes and overall program effectiveness. In addition, the impact of these programs on the individuals and communities they serve in CA remains largely unknown.

Proposed Project:

The proposed Innovation project seeks to:

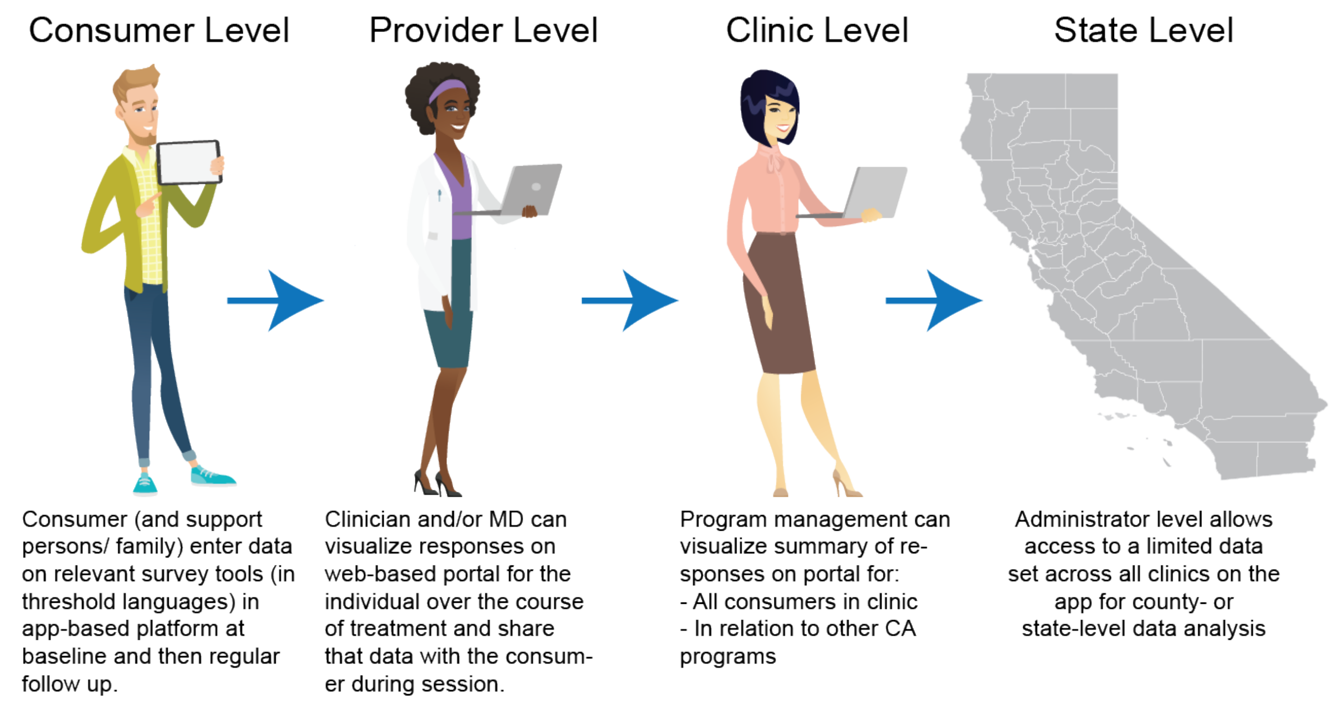
1) Develop an EP learning health care network (LHCN) software application (app) to support ongoing data-driven learning and program development across the state
2) Utilize a collaborative statewide evaluation to:
    a. Examine the impact of the LHCN on the EP care network
    b. Evaluate the effect of EP programs on the consumer- and program-level outcomes.

Eight counties (Los Angeles, Orange, San Diego, Solano, Napa, Sonoma, Stanislaus, and Kern), in collaboration with the UC Davis Behavioral Health Center of Excellence and One Mind, are seeking approval from the Mental Health Services Oversight and Accountability Commission (MHSOAC) to use Innovation Funds to develop the infrastructure for a sustainable LHCN for EP programs, the utility of which will be tested through a robust statewide evaluation. This project, led by UC Davis in partnership with UC San Francisco, UC San Diego, University of Calgary and a number of California counties, will bring consumer-level data to the clinician's fingertips, allow programs to learn from each other, and position the state to participate in the development of a national network to inform and improve care for individuals with early psychosis across the US. The evaluation would assess the impact of the LHCN on consumer- and program-level metrics, as well as utilization and cost rates of EP programs. This will allow counties to adjust their programs based on lessons learned through multiple research approaches. One Mind, a foundation focused on improving brain health outcomes, has partnered in this project to enhance available resource to support achievement of project goals in a timely fashion.

Background Research on Innovation Component

The foundation for the proposed California EP LHCN and associated evaluation was developed through a prior MHSOAC-funded project (14MHSOAC010), which sought to develop a method for evaluating publicly funded EP programs statewide. Based on the current research literature, cumulative findings of the previous project, and stakeholder input, it became clear that EP program consumers, providers and county supports wanted to have immediate access to their data in real time at various levels (see Figure 1 below).

Figure 1. Proposed LHCN for CA Mental Health Programs



Through a collaborative county-led development process, a number of advantages of collecting such data in this manner were identified. For example:

- Consumers and their families and EP providers could review individual-level data while in session together to help identify needs, support the delivery of consumer-centered care, and help understand what factors may be contributing to treatment progress.
- Clinic managers or county administrators could visualize data across the program and compare program averages to a statewide benchmark to help identify possible areas for program-level improvement.
- At the highest level, this data could be de-identified and combined across counties to support large-scale analysis to identify system-wide strengths or areas of need.

While this project was initially conceived as an evaluation, stakeholder input shifted the focus to development of a LHCN where the system rapidly accumulates data from routine clinical practice and makes it immediately available to improve clinical care. EP programs and their associated counties recognized the unique opportunity to have longitudinal consumer- and service-level clinical data available to providers and their consumers in real-time that can be used as part of the consultation. In addition, they also recognized that this network would allow them the opportunity for improved outcome recording and reporting, which can be used for service planning and improving standards of care via comparison to a statewide benchmark. These stakeholders proposed that this could serve as the basis for an EP learning collaborative, through which programs or counties could use the data to identify areas of unmet clinical or training needs, identify which service components drive outcomes in a particular area, collaborate to hold trainings, and learn from each other's successes and struggles. Through the network, these otherwise disparate programs could come together to learn, grow and improve.

In addition, this Innovation project would leverage the California LHCN to support our potential participation in a national early psychosis LHCN, which will be funded by the National Institute of Mental Health (NIMH). The NIMH is interested in developing a national network of EP programs – named EPINET – but involvement in this national network requires the participating states to have established infrastructure for large scale data collection and reporting. California has the largest dissemination of EP services in the US. However, at present we lack the infrastructure to participate in this network. By systematically designing outcome reporting for counties across the state, the LHCN moves beyond simple program level evaluation and lays the groundwork for linking data on both a state and national level, to address more complex questions about best practices.

The participation of the counties and programs co-authoring this proposal, in addition to support from One Mind, demonstrates the anticipated value of the LHCN and statewide evaluation. We have a unique opportunity to build a coalition of counties, their partnered programs, and leading researchers in EP services to share lessons about what works for consumers and their families across the state using qualitative and quantitative methods. With this innovative proposal, the state will have data input from consumers, family members and providers as well as quantitative impacts such as service utilization, hospitalizations, and crisis utilization. The LHCN and the statewide evaluation dovetail to inform early psychosis care across the state. It is our aim to use the LHCN as a resource and a tool for the counties before, during and after a formal evaluation, and to sustain the network beyond the 5-year project for ongoing benefit to the counties involved and the state of California.

Stakeholder Input in Project Development

In addition to stakeholder input as part of the prior MHSOAC funded project, priorities for implementation of this LHCN and statewide evaluation were identified in a series of stakeholder meetings conducted in 2017 and 2018 with relevant county and program leaders, individuals with lived experience of psychosis, and family members of those with lived experience. Three common themes were prevalent in all conversations – utility, relevance to real-world outcomes, and sustainability.

Stakeholders reported immediate value in the utility of electronic tablet data collection and the ability to display outcomes data at the individual level for use during clinical visits, at the program level for internal quality improvement, and at the state level for system level learning. Stakeholders representing consumers and family members felt that this access to data was exciting and would likely increase engagement in care. Because of this, the evaluation team has prioritized the utility of the data collected in real-time.

All stakeholders, especially individuals and family members, wanted to prioritize measures relevant to their experience and real-world outcomes. Stakeholders were presented with options for self-report measures that have been previously selected for use in community-based early psychosis programs by a national workgroup, based on validity, ease of data collection and clinical utility (www.phenxtoolkit.org), as well as additional measures for domains not represented in the toolkit. Starting from this working list, the final set of outcome measures will be selected in Year 1 of the proposed project based on the outcomes of a series of focus groups with EP providers, county and state representatives, consumers and family members, across all participating EP programs. Mental Health America has agreed to support recruitment for these focus groups. We will develop a list of core measures that will be collected across all programs, and a supplementary list which will include outcome measures that can be added to an individual program’s battery to address any program- or county-specific needs.

For county- and state-level stakeholders, data on costs and utilization in the EP programs, crisis/ED services and hospitals, and homelessness for the seriously mentally ill (SMI) were highlighted as key areas of interest. The ability to understand how EP programs yield differential utilization of high-cost services versus standard outpatient care is essential to clarify the impact of these programs on the communities that they serve and support ongoing funding. Stakeholders felt that combining the EP program level data collected directly from consumers and family members with the cost and utilization data will help counties and programs to understand the consumer- and program-level factors that contribute to increased utilization of high-cost services, thereby enabling targeted decisions around program level changes to mitigate those costs.

Finally, the program and county stakeholders reported that plans for sustainability after the project end date are important for their ongoing interest. As part of the project, we will calculate true costs to programs for implementation of the LHCN tablets within daily clinic operations, including costs to sustain the LHCN app, staff time to support data collection, and ongoing training needs, to inform future decisions around sustainability. Additional California counties and EP programs have expressed an interest in the LHCN (Kern, Santa Barbara, Marin, Ventura, San Mateo), highlighting growing interest in the potential of the LHCN for CA.

The counties affiliated with this current proposal and their respective program partners have all agreed to participate in the development of the LHCN, and its evaluation, in collaboration with project partners at UC Davis, UC San Francisco, UC San Diego, University of Calgary and One Mind.

Overall Goals

1. Implement a LHCN app for early psychosis programs across multiple California counties.
2. Develop a LHCN implementation strategy that could be adopted by EP programs statewide.
3. Evaluate the impact of the LHCN on consumer satisfaction with care, insight into treatment needs, and alliance with the treatment team, as well as consumer and provider experience implementing the LHCN.
4. Demonstrate the utility of the LHCN through a multilevel evaluation of: a) the EP program components associated with improved consumer level outcomes, b) the potential differences in service utilization and costs (EP program, ED/crisis, hospital) between EP programs and standard care for EP consumers from de-identified county level data, and c) the consumer, family and EP provider experiences related to participation in the LHCN.

Consumer/Target Population

The target population or intended beneficiaries/users of this LHCN are:

- Individuals at increased risk or in the early stages of a psychotic disorder
- Family members, caregivers, or other support persons
- EP program providers
- County and EP program leadership
- State leadership and policy makers

Learning Goals and Project Aims

Through the development of the LHCN and the associated evaluation, we will answer the following questions:

1. Do consumer and/or provider skills, beliefs and attitudes about technology or measurement-

based care impact completion of LHCN outcome measures or use of data in care?

2. Does engagement in the LHCN impact consumer satisfaction with care, insight into treatment needs, and alliance with the treatment team?
3. Are there differences in utilization and costs between EP programs and standard care?
4. How does utilization and cost relate to consumer-level outcomes within EP programs?
5. What are the EP program components associated with consumer-level short-and long-term outcomes in particular domains?
6. Within EP programs, what program components lead to more or less utilization (e.g. hospitalization)?
7. To what extent do California EP programs deliver high fidelity to evidence-based care, and is fidelity related to consumer-level outcomes?
8. What are the barriers and facilitators to implementing a LHCN app across EP services?
9. What are the consumer, family and provider experiences of submitting and utilizing data obtained through the LHCN during routine clinical care?
10. Does a technology-based LHCN increase use of consumer-level data in care planning relative to a program's prior practice?
11. Does use of consumer-level data increase consumer insight into treatment needs, promote alliance with the treatment team, or improve satisfaction with care?
12. What will be a viable strategy to implement a statewide LHCN for EP programs?

Evaluation Plan

1. Utility of the Learning Health Care Network for Early Psychosis Programs

To examine the utility of the LHCN for EP consumers and providers, the evaluation will examine the impact of the LHCN on the counties and their services. We predict that the easy-to-access, on-demand data collected via the LHCN, in addition to provider training in how to fully utilize and share information with consumers and family members will increase the use of data in treatment planning and care decisions, moving the system toward measurement-based care. Further, our previous experience implementing mobile health technology in community-based EP programs (Kumar et al., 2018; Niendam et al., 2018) suggests that this project will improve consumer satisfaction with care, increase insight into their treatment needs, and enhance their alliance with the treatment team.

To address this question, the evaluation will gather information from a sample of EP consumers and providers prior to LHCN implementation, and from another sample of EP consumers and their providers after LHCN implementation. Consumers in the pre-implementation period (Year 1) will be asked to complete self-report questionnaires about Insight into illness, Perceived Effect of Use for the LHCN, Treatment Satisfaction, Treatment Alliance, and Comfort with Technology. Providers will complete questionnaires on Treatment Alliance, Use of Data in Care Planning, Perceived Effect of Use for the LHCN, and Comfort with Technology. After LHCN implementation (Year 4), a new group of consumers and their providers will complete the same self-report questionnaires. In both phases, consumers and providers will complete the questionnaires approximately 6 months after consumers' entry into the EP programs. This data will be compared and then combined with stakeholder feedback and qualitative results to understand the impact of the LHCN on the consumer and provider experience.

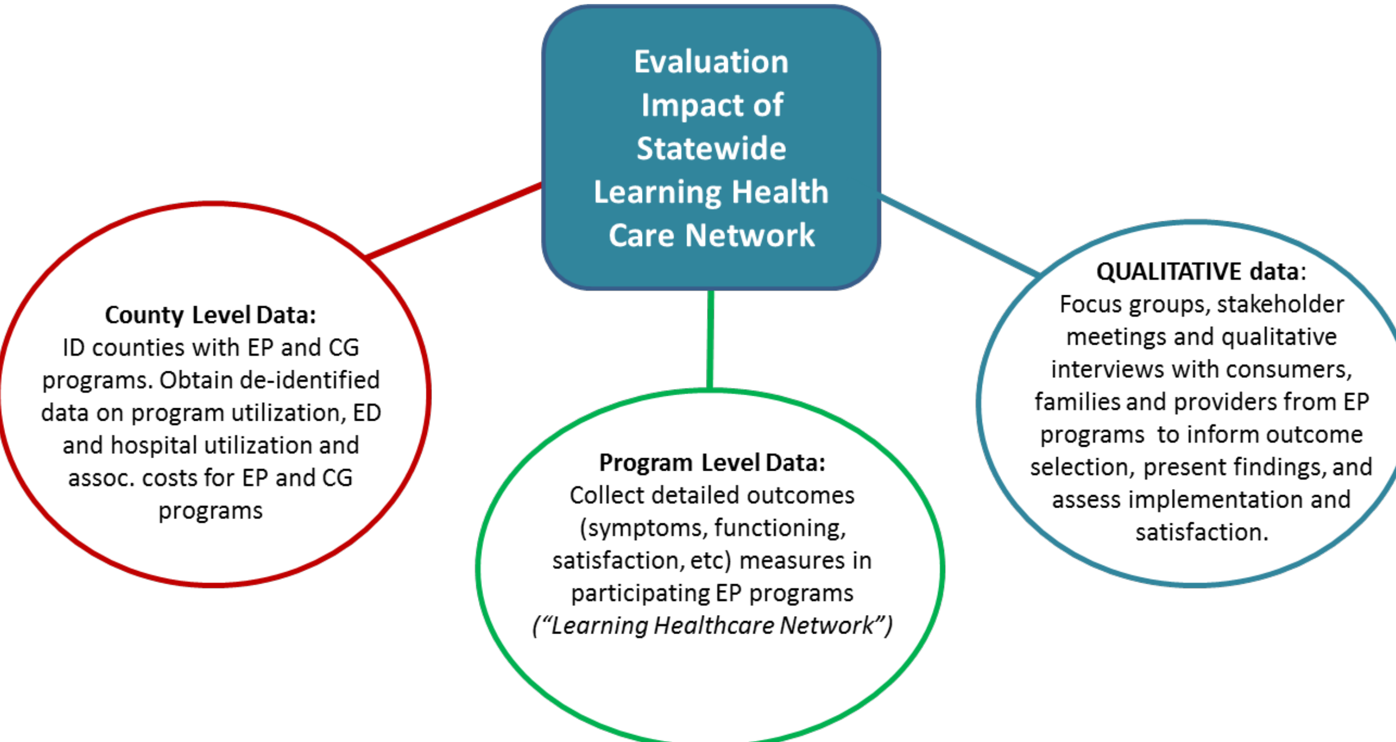
2. Evaluation of Early Psychosis Program Fidelity

Each participating clinic will undergo a fidelity assessment to determine their adherence to evidence-based practices for first-episode services using a revised version of the First Episode Psychosis Services Fidelity Scale (FEPS-FS). The FEPS-FS represents a standardized measure of fidelity to EP program best practices (Addington et al., 2016; First Episode Psychosis Services Fidelity Scale: (FEPS-FS 1.0), 2015). The FEPS-FS was developed using an international expert consensus method, focused on six domains: (1) population-level interventions and access, (2) comprehensive assessment and care plan, (3) individual-level intervention, (4) group-level interventions, (5) service system and models of intervention, and (6) evaluation and quality improvement. This scale was tested for reliability in six EP programs in the United States and Canada, and an accompanying FEPS-FS 1.0 Fidelity Review Manual was developed for future program review. The FEPS-FS has been recently revised to meet the agreed upon standards of EP care in the US and allow large-scale fidelity evaluation. In the proposed statewide evaluation, each EP program will participate in an assessment of EP program components using the revised FEPS-FS, which will be completed on-site or via web-based teleconference. The resulting score will be used as part of the statewide analysis. These assessments will be conducted in consultation with Don Addington, M.D. from the University of Calgary, author of the FEPS-FS scale. Dr. Addington will serve as a Co-Investigator on this project and provide oversight and support for the fidelity evaluations and interpretation of other outcomes data related to components of care. The ability to evaluate the impact of service-level factors on consumer-level outcomes collected by tablets is a key component of adopting features of a LHCN. This will provide us with important new insights into what particular components of the EP program of care are associated with improved outcomes in different domains. These findings can then be disseminated across the network (and beyond), further informing care and shaping service delivery.

3. Impact of Early Psychosis Programs on Costs and Outcomes

This portion of the evaluation is divided into three data components: program-level, county-level, and qualitative (See Figure 2 below). The first component (program-level), which serves as the foundation for the LHCN, utilizes a prospective, longitudinal approach to gather consumer level data elements for EP programs on core outcomes in six-month intervals across 24 months, starting at the intake assessment. The second component (county-level), modeled after a pilot analysis in Sacramento County, will focus on county-level administrative data related to consumer's program service utilization, crisis/ED utilization (if available), psychiatric hospitalization, and costs associated with these utilization domains. Service utilization and costs will be compared between EP and comparator outpatient programs in that county who serve similar consumers with EP diagnoses (Niendam et al., 2016). These comparator programs will be identified by input from county representatives, and an evaluation of county level data to identify where first-episode psychosis consumers are typically treated in their county outside of the EP program. The third component (qualitative) incorporates qualitative interviews, stakeholder meetings and focus groups with EP providers, consumers, family members, county representatives and regulators to determine which outcomes should be incorporated into the program-level evaluation, inform the design of the program-level data collection system, identify challenges and solutions to implementing the LCHN, and to provide their experiences of delivering or receiving services under this model of care. Taken together, we believe these 3 components will provide a rich, comprehensive summary of the impact of EP programming in California where counties and programs across the state can learn from each other about what works and what can be improved. Each evaluation component is explained in detail below.

Figure 2. Three components of the evaluation associated with the Statewide LHCN.



Program-level Data Component

This component of the statewide evaluation will focus on a longitudinal, prospective study of core data elements for EP, which will serve as the foundation for the statewide LHCN. This component includes final identification of core data elements, which are considered appropriate and useful by EP programs via stakeholder engagement discussions, and determination of appropriate methods for data collection. Recovery-oriented data elements will be included to understand program impact across domains that are important to stakeholders and may not be reflected in more traditional outcome measures. As noted in stakeholder feedback, consumers and families will directly provide data via questionnaires, which would reduce the data entry burden on clinic staff. If data elements are seen as useful metrics of program goals, the collection of outcomes data in this method could increase motivation for participation by EP programs and address stakeholder's desire to participate in the LHCN.

In this component, EP program providers and leadership, consumers and family members will be engaged to identify measures of potential outcomes selected from the PhenX Early Psychosis Toolkit (https://www.phenxtoolkit.org/index.php) and those currently in use by the national Mental Health Block Grant 10% set-aside evaluation of EP programming (see Table 3 on Outcomes below), as well as additional relevant domains. Consistent with other approaches to evaluation (Full Service Partnership Toolkit, 2012), short and long-term outcomes as well as outcomes prioritized by cultural minority groups will be considered. Once measures are selected by the stakeholders, a prioritization process will be used to identify core outcome domains and measures that can be collected across EP programs. A method of data collection will be developed that aligns with EP program workflows, to reduce burden on EP providers, consumers and families. EP programs will complete the outcomes evaluation at baseline, and every 6 months thereafter (24 months total). Programs will also provide information on each participating consumer's diagnosis and demographics. All information will be de-identified at the program level before being submitted to the UC evaluation team.

A primary incentive for county participation is the technologically innovative component of the program-level analysis, which will serve as the foundation for the LHCN. Consumers will self-report outcomes on tablets, with access to discuss the results directly with their providers, supporting a consumer-centered approach to care while reducing provider burden. That data will be visualized in real-time on a web-based provider-facing dashboard. EP providers will receive support in how to utilize this data during consumer sessions to illustrate their progress toward recovery and inform collaborative treatment planning. The dashboard will also provide summaries at the program level to aid in program decision-making based on patterns or trends. A core set of outcome measures will be collected uniformly across the five counties, so that a program's data can also be compared to a statewide average, to provide guidance on where training or technical assistance could be helpful to improve program outcomes.

Based on estimated numbers from our previous descriptive summary of programs in California, we will expect to enroll and obtain 12-month outcome data on approximately 2000-2500 individuals, with a subset of individuals providing outcome data at 18 and 24 months (Niendam et al., 2017). Outcome on each domain will be modeled longitudinally, controlling for any demographic differences between counties (e.g. age, gender, race/ethnicity). Similarly, scores on the program fidelity assessment will be tested to determine its impact on consumer-level outcomes.

Table 1. Possible Outcomes, Sources of Outcome Data, and Methods to Determine Costs Associated with Outcomes

Potential Outcomes of Interest	Sources of Data on Relevant Outcomes	Levels of Analysis	Sources of Cost Data associated with Outcomes
COUNTY LEVEL DATA VARIABLES			
Inpatient hospitalization for mental health concerns	• County hospitalization records	• Number/proportion of individuals hospitalized per group • Number of hospitalizations per group • Number of hospitalizations per individual • Duration of each hospitalization (days) • Total duration of hospitalizations (days) per individual	• Daily rate paid by County • Daily rate Medi-Cal reimbursement
Emergency Department or Crisis stabilization	• County crisis stabilization unit records	• Number/proportion of individuals with crisis visits per group • Number of visits per group • Duration of each visit (hours)	• Hourly rate paid by County
Outpatient service utilization	• Service unit records by outpatient program from County	• Service type • Number of service units (minutes)	• Contract service unit rates

Potential Outcomes of Interest	Sources of Data on Relevant Outcomes	Levels of Analysis	Sources of Cost Data associated with Outcomes
PROGRAM-LEVEL DATA VARIABLES			
Psychiatric Symptoms	Modified Colorado Symptom Index (CSI)* (Ciarlo & Reihman, 1977; Shern et al., 1994)	Frequency of positive, mood, and cognitive symptoms	*Self-report designed for adults 18+*
	Brief Psychiatric Rating Scale (BPRS)* (Overall, 1961)	Comprehensive evaluation of positive, negative, and affective symptoms	*Providers-administered*
Psychosis Recovery	The Questionnaire about the Process of Recovery (QPR) (Neil et al., 2009)	Consumer perception of recovery from psychosis	*Self-report designed for adults 18+*
Social and Role Functioning	Global Functioning: Social and Global Functioning (Cornblatt et al., 2007)	Current social functioning, and highest and lowest functioning in the year prior to assessment	*Providers-administered for adolescents and adults 12+*
	MIRECC Global Assessment of Functioning (GAF)* (Niv, Cohen, Sullivan, & Young, 2007)	Occupational functioning, social functioning, and symptom severity	*Providers-administered*
Personal Well-being	Personal Well-being Index (Cummins, Eckersley, Pallant, Van Vugt, & Misajon, 2003; Tomyn, Tyszkiewicz, & Cummins, 2013)	Satisfaction with standard of living, health, life achievement, personal relationships, personal safety, community connectedness, and future security	*Self-report with both adult and child forms*
	Lehman Quality of Life Scale* (Lehman, 1988)	Quality of life in chronic mental illness	*Providers-administered*
Antipsychotic Medication Side Effects	Glasgow Antipsychotic Side-effect Scale (GASS) (Waddell & Taylor, 2008)	Consumer's viewpoint about suffering due to excessive side effects from antipsychotic medication	*Self-report designed for adults 18+*
	Extrapyramidal Symptom Rating Scale (ESRS) (Chouinard & Margolese, 2005)	Drug-induced movement, balance, and muscle tone related side effects	*Providers-administered for adults 18+*
Antipsychotic Medication Adherence	Brief Adherence Scale (BARS) (Byerly, Nakonezny, & Rush, 2008)	Consumer's medication taking behaviors	*Providers-administered for adults 18+*
Family Functioning	Systematic Clinical Outcome Routine Evaluation (SCORE-15) (Stratton, Bland, Janes, & Lask, 2010)	Family difficulties, strengths, and communication	*Self-report*
Family Burden of Mental Illness	Burden Assessment Scale (BAS) (Reinhard, Gubman, Horwitz, & Minsky, 1994)	Burden on families with family members that are experiencing severe mental illness	*Self-report designed for adults 18+*

Incarceration	The National Survey on Drug Use and Health (NSDUH) 2014 Questionnaire (1997)	Arrests, legal contact, and probation information for the year prior to assessment	*Self-report with both adult and child forms*
Risk for Homelessness	Homelessness Screening Clinical Reminder (Montgomery, Fargo, Kane, & Culhane, 2014)	Risk of future homelessness in adults	*Provider administered screening tool for adults*
	At-Risk of Homelessness Indicator (Chamberlain & MacKenzie, 1996)	Risk of future homelessness in young people	*Self-report designed for school aged youth*
Physical Activity	The International Physical Activity Questionnaire (IPAQ) (Lee, Macfarlane, Lam, & Stewart, 2011)	Physical activity in the week prior to assessment	*Providers-administered for adolescents and adults 15+*
Mental Health Services Satisfaction	MHSIP Youth Services Survey (YSS) (Brunk, Koch, & McCall, 2000)	Consumer's viewpoint on service satisfaction	*Self-report for adolescents ages 13-18*
	Recovery Self-Assessment (RSA) (O'Connell, Tondora, Croog, Evans, & Davidson, 2005)	Perceptions of recovery, quality of services, and staff helpfulness and responsiveness	*Self-report for adults 18+, with family member and provider variants*

These measures are currently used by the MHBG 10% Study

Qualitative Data Component

The main focus of this component is the collection, interpretation and integration of county and state representative, EP program providers and leadership, consumer, and family stakeholder input across all aspects of the project. Prior to data collection, an Advisory Committee consisting of consumers and family members of service users, EP providers, researchers. and county and state representatives will be recruited with the aim of providing input at each stage of the project. This Advisory Committee will convene every 6 months, and when needed, to provide input at the initiation and submission of the major project deliverables detailed below.

In the first year, focus groups with providers, consumers, family members, and state and county representatives will be conducted to identify which measures represent outcomes that are both meaningful and are feasible to implement in routine clinical practice, as described earlier. Following outcome selection, further focus groups will be held to inform the application development and dashboard design at different stages of the process to ensure that the system will be appropriate for use in a clinical setting.

Following the initial rollout of the tablets to the pilot EP program sites, a qualitative evaluation of the implementation strategy for the LHCN will be conducted in order assess its feasibility, and to identify any barriers which may need to be addressed prior to full rollout across all programs. In-depth, semi-structured interviews with consumers, family members, and providers will be conducted. Interview guides will be developed in collaboration with service users, family members, providers and county representatives to ensure that all areas deemed relevant to stakeholders are considered. Input from stakeholders in the analysis and interpretation of the data will be sought to support the validity of the findings. The aim of this investigation will be to identify any facilitators that have been found to improve the implementation of the LHCN at a site level, and identify any significant barriers to successful implementation, with a proposal of strategies to address such barriers.

MHSA programs strive to provide services to consumers with a patient-centered focus to consumers' treatment goals (MHSA, 2005). With this in mind, consumer, family and provider experiences of delivering or receiving care within a LHCN will also be explored once the data collection systems are in full operation. This investigation will focus on the acceptability of the LHCN procedures to consumers, providers, and families; the impact of the LHCN on treatment engagement and satisfaction with care; and experiences of the data being used in routine clinical practice. At project end, a stakeholder meeting with consumers, family members, providers, county representatives and sponsors will be held to present the project findings, and receive further feedback to help shape future EP LHCN implementation efforts both across the state and nationwide. Mental Health America has agreed to support recruitment for these focus groups.

County-level Data Component

The proposed analysis is based on the pilot work conducted in Sacramento County, scaled to multiple counties (Niendam et al., 2016). It focuses on consumer level data related to program service utilization, crisis/ED utilization, and psychiatric hospitalization and costs associated with these utilization domains. First, EP individuals entering the EP programs during a specified period will be identified. To compare the utilization and costs of the EP program to what they would be without the program, an appropriate comparison group is an essential component of this evaluation. Therefore, the proposed analysis of utilization and costs includes data collected as part of regular operations standard outpatient (comparator) programs during the same timeframe in the same community. Individuals with EP diagnoses, within the same age group, who enter standard care outpatient programs during that same time period will be identified as part of the comparator group (CG). Comparator group programs will be identified by input from county representatives, and an evaluation of county level data to identify where first-episode psychosis mental health consumers are typically treated in their county when not receiving specialty EP program services. Categories of service utilization will include, at a minimum, outpatient, inpatient and emergency services. It may also include justice system mental health use, if those data are available. Next, costs per unit of service will be assigned to each type of service, per provider, based on cost reports submitted to the counties from the provider clinics. All information will be de-identified at the program level before being submitted to the evaluation team.

Analyses of service utilization for both groups (EP and CG) will focus on two time periods: 1) the three years prior to the start of this project (e.g. July 2015 – June 2018) to harmonize data across counties and 2) for the 3.5-year period contemporaneous with the prospective EP program level data collection to account for potential historical trends during the evaluation period. Mean service utilization, by service type, will be modeled longitudinally between EP and CG groups, controlling for any demographic differences between groups (e.g. age, gender, race/ethnicity, socioeconomic status). Similarly, costs associated with service use would also be modeled longitudinally between groups. Scores on the FEPS survey will be tested as a moderator of both service use and costs, within the EP clinics.

The evaluation team will establish a shared database with harmonized data from multiple counties. This requires partnering closely with county representatives, EP and CG programs. This process will be linked closely to the qualitative component of the evaluation to identify barriers and problem-solve solutions to those barriers, such as how to make the data export most efficient for counties. The collection of county-level data would overlap with the program-level data component described above. We anticipate that each county formats their utilization and cost data somewhat differently, so that each individual county's data would require analysis to clean the data and create a common format for all data elements across participating counties. This would enable the final analysis to combine data across counties, using a modeling approach that adjusts for the clustering of data

within counties. Multiple stakeholders will be involved in all stages of the analysis, regarding study design, analysis and obtaining feedback on results of both the pilot and full study phases.

County Participation in Each Component of the LHCN

The initial group of counties that established the LHCN will participate in all components of the LHCN, described above. Those initial counties include Los Angeles, Napa, Orange, San Diego, and Solano Counties. As additional counties join the collaborative, they will have the option of selecting which component of the project they would like to participate in. Sonoma County will only be participating in the program-level component and fidelity assessment. Stanislaus and Kern Counties will be participating in all of the available components of the LHCN.

Protecting Privacy and Confidentiality

Counties will provide de-identified information on consumer-level utilization and associated costs for the fiscal years specified in the proposal. This will be for individuals in the EP program as well as individuals identified in comparator programs within the county. EP programs will enroll individuals in the online data collection system ("learning health care network app") that will collect data on a variety of self-report questionnaires as well as basic demographic data (sex, race/ethnicity, year born – see PHI note below) that is tied to their participant ID. Consumers will complete these surveys at baseline and every 6 months thereafter until the end of 24 month follow up. This data will be available to the consumers and EP program providers on the dashboard (via visualizations and data sheets) at an individually identifiable level, but only de-identified data will be available at the UC Davis level. Stakeholders (consumers, families, providers, county representatives) will be asked to provide feedback throughout the project, including participation in focus groups and qualitative interviews, that will ask their opinion and experiences as part of the project. Participants' responses will be recorded via handheld digital recorders or via secure conference lines (via ReadyTalk). All response audio files will be de-identified, removed of all 18 PHI identifiers, and then transcribed to document responses prior to analysis. Individuals participating in interviews are notified of this process at time of scheduling and prior to starting the interview.

Any data that is shared with UC Davis will have all PHI (protected health Information) identifiers removed except for zip code. We will work to ensure that we have enough demographic information to do meaningful analysis, but avoid combinations of PHI that could identify the individual. For example, we would ask for consumer age and their year of birth, but not their DOB (please see https://research.ucdavis.edu/policiescompliance/irb-admin/researchers/hipaa/ for more information). We will work with each county to develop a unique participant ID that will be tied to each consumer in the data. UC Davis will be provided with the participant IDs only, but the county and EP program will be able to link that to the specific person. We tend to call this the "participant ID list."

Data will be stored at UC Davis; some data will also be stored at UCSF and UCSD with similar protections outlined below. The study investigators and primary research team are the only ones who will have access to the data. It will not be released to others. For the electronic files and data sets, copies of each file will be maintained on the Project Manager's password-protected computer, and backup copies, will be kept on a password-protected removable computer drive. All copies of these electronic files will also be encrypted. All Windows-based computers are locally protected by Windows Firewall, and by the use of IPSec security policies that block external access to the computers. The UCDHS Sacramento campus uses a border firewall to block incoming access to their subnets. The hard drives of all computers at UC Davis are protected by Private Key Full-Disk Encryption, rendering all data unreadable in the event the computer is accessed without permission

or removed from the Center. Data will be stored for 48 months after the end of the project to allow ongoing data analysis and publication.

Data will not contain PHI related to consumers, family members or EP providers who completed surveys. Any identifying information from individuals who completed qualitative interviews will be removed during the interview transcription process to de-identify the qualitative data. These individuals will not be identified by name in any reporting of results – only summary themes will be reported. In addition, we will utilize all standard protections to safeguard all of this data. Investigators will follow applicable University policies (UC Davis Hospital Policy 1313, UCDHS P&P 2300-2499, and UC Business and Finance Bulletin on Information Security (IS-3)). For the electronic files and data sets, copies of each file will be maintained on the Project Manager's password-protected computer, and backup copies will be kept on a password-protected removable computer drive. All copies of these electronic files will also be encrypted. Beyond data coding in the study electronic data files, additional steps will be taken to further ensure study data security. One will be to ensure that only authorized staff will have access to the data files, as determined by the PI. Another will be to ensure that all authorized staff have undergone appropriate briefing from the PI and project manager on techniques for maintaining electronic data security and confidentiality before they are allowed to access and use the data files. The third step will be that only the study project manager, Dr. Tara Niendam, and Dr. Joy Melnikow will be allowed to provide data files to other individuals. The fourth will be to minimize e-mailing of electronic study data files by any personnel. E-mailing of files will only be allowed if data is de-identified and can be sent via encrypted, password protected messaging. All Windows-based computers are locally protected by Windows Firewall, and by the use of IPSec security policies that block external access to the computers. The UCDHS Sacramento campus and UCSF Department of Psychiatry use a border firewall to block incoming access to their subnets. The CHPR computers are thus "doubly-secured," falling under the protection of both the UCDHS physical firewall and machine-based security policies. The hard drives of all computers at the Center are protected by Private Key Full-Disk Encryption, rendering all data unreadable in the event the computer is accessed without permission or removed from the Center.

Contracting for County Collaborative

UC Davis will be working with Office of Research to develop contracts with each participating county. Some counties may choose to directly contract with UC Davis for this project, while other counties may choose to contract through the JPA with CalMHSA.

A grant, totaling $1.5 million over 5 years, will be provided by One Mind to support the development and implementation of the LHCN project. The contract for this grant will be established separately between UC Davis and One Mind.

Contracting for Application and Dashboard Development

The program level data will be acquired on a software application and dashboard (Beehive) built specifically for the program and county needs. To date, we have worked with Quorum and its affiliate, x-cube Labs, to develop the current Beehive platform, which will be modified for the purpose of this project. In Year 1, UC Davis will execute a service contract with Quorum/xcube labs for the modifications required by this project. We will get feedback from providers, stakeholders, and focus groups during each step of the development process. Our team has previous experience in implementing this type of technology in the UC Davis Early Psychosis Programs and has found that health software applications are useful to both consumers and providers to assess and monitor consumer outcomes of interest. The software application and web-based dashboard will be

developed with all appropriate protections for consumer information according to HIPAA. Additional protections for data privacy are described below.

Ongoing Community Program Planning

Community involvement from various stakeholders is considered a central piece to the development and implementation of the project. From the outset, the focus of this project has shifted from an evaluation of the effectiveness and cost effectiveness of EP programs developed in a previous MHSOAC funded project (grant ID: 14MHSOAC010) to the current proposal based on the input from consumers, families, providers and county staff. This input has been received via Advisory Committees held under the previous project, feedback from consumer and family advocacy groups such as the National Alliance on Mental Illness (NAMI) and Mental Health America (MHA), and from a series of consultations with EP providers and county staff across six California counties.

The proposed project follows a policy of 'nothing about us without us', including community stakeholder involvement at all levels of the project. One feature of this will include consumer and family member representation on our Advisory Committee, which will meet regularly to oversee the implementation of all aspects of the project and propose changes where necessary. Another is the strong emphasis on the qualitative component of the investigation that will conduct focus groups and qualitative interviews with consumers, family members, providers and county representatives to ensure their views are considered at each stage of project implementation. This will include outcome selection, usability testing of the data collection and visualization software, exploring potential challenges and solutions to early implementation efforts in view to improving procedures, exploring experiences of delivering and receiving services in this new system of care following full implementation, and finally conducting feedback sessions at the end of the project to further the sustainability of the LHCN. Community involvement will be sought in the analysis and interpretation of these qualitative findings to support the validity of these findings, and to further improve community representation.

Proposed Implementation Timeline and Dissemination Strategies

A full implementation timeline of the different components of the LHCN development, implementation and evaluation, in addition to the activities to be undertaken by the EP and county-level representatives, is presented in Table 1. We estimate that this project will start January 1, 2019 and end on December 31, 2023 (5-year project). Implementation activities over the 5-year timeline will include:

<u>Year 1</u>: Contracting, IRB submissions, initiating advisory group meetings, focus groups to identify outcomes for the program-level evaluation, and preliminary development of wire frame[1] and data visualization for the LHCN application and web-based dashboard. Consumers and their providers will complete surveys prior to LHCN implementation.

<u>Year 2</u>: Qualitative evaluation activities will include conducting fidelity assessments of EP programs and running focus groups to inform the development of the program-level data collection and visualization software. Program-level evaluation activities will include finalizing the outcome selection, beta testing the data collection and visualization software, training providers in data collection methods, and the initiation of pilot testing of program level-data collection practices. County-level evaluation activities include finalizing the methods for the county evaluation and obtaining county-

[1] Wireframe: an image or set of images, which displays the functional elements of the app, used for planning our app's structure and functionality from a user perspective.

level data covering a 3-year prior timeframe.

Year 3: Qualitative evaluation activities will include conducting interviews to determine barriers/facilitators to implementation, and consumer and provider experiences of receiving or delivering care with the new LHCN. Program-level evaluation activities include extending the training and implementation of the data collection across all five counties. County-level evaluation activities include running the analysis from the 3-year prior data pull and amending procedures in preparation for the county-level analysis of data.

Year 4: Qualitative evaluation activities include interviews of consumers, families and providers relating to their experiences receiving or delivering care within the LHCN across all six counties. Program-level evaluation activities include ongoing data collection across all sites. Consumers and their providers will complete surveys after LHCN implementation. County-level evaluation activities obtaining and analyzing the second round of county-level data.

Year 5: Qualitative evaluation activities will focus primarily on the dissemination of findings and focus groups to solicit feedback for future improvements. Program- and County-level evaluation activities will include continued data collection, and the final analysis.

Table 2: Detailed Project Timeline

(YEAR 1: period 1)				
Evaluation Team			EP program providers	County Staff
Program	County	Qualitative		
-Contracting with County -Build platform for app - Site visit, present study, complete review of EP programs current assessment practices - Prioritize outcomes and measures to be used -UC Davis IRB preparation and submission	-Contracting and MOUs with UC Davis -IRB preparation and submission	-Recruit for external consumer advisory group and focus groups. -IRB submission	-Contracting and MOUs with County -Support access to stakeholders for feedback -Support recruitment of external consumer advisory board	-Contracting and MOUs with UC Davis and EP Programs -Identify key staff for data transfer
(YEAR 1: period 2)				
Evaluation Team			**EP program providers**	**County Staff**
Program	**County**	**Qualitative**		
- Select outcomes and measures to be used -Update data collection method -Review wire frame and data visualization with stakeholders - UC Davis IRB approval -Pre-LHCN implementation questionnaires	-Discuss methods and identify available data for 5-county-integrated evaluation -IRB approval by counties	-Focus groups; outcome selection and feedback on wireframe and data visualization -Begin external consumer advisory group meetings	-Provide feedback on outcome measures Participate in prioritization process -Support access to stakeholders for feedback	-Participate in prioritization process -Identify key staff for data transfer

(YEAR 2: period 1)				
Evaluation Team			EP program providers	County Staff
Program	County	Qualitative		
-Finalize outcomes and measures to be used -Beta test of app for data collection -Pilot testing in 2 EP programs begins	-Finalize methods for 5-county-integrated evaluation	-Fidelity assessments -Focus group on app and dashboard	-Provide feedback on outcome measures - Participate in prioritization process -Support access to stakeholders for feedback	-Participate in prioritization process -Identify key staff for data transfer

(YEAR 2: period 2)				
Evaluation Team			EP program providers	County Staff
Program	County	Qualitative		
-Training in data collection -Pilot testing in 2 EP programs -Incorporate feedback into application	-Obtain data from prior 3-year timeframe for preliminary 5-county integrated evaluation for both EP and CG programs	- Fidelity assessments - Focus groups on app	-Pilot of app in 2 EP clinics -Provide feedback during interviews -Support access to stakeholders for feedback -Participate in fidelity interviews	-Send data from prior 3-year timeframe for EP and CG programs -Provide feedback during interviews

(YEAR 3: period 1)				
Evaluation Team			EP program providers	County Staff
Program	County	Qualitative		
-Training and implementation of outcomes measurement in 5 EP programs	-Analyze and report findings on data from preliminary 5-county integrated evaluation	-Barriers/ facilitators to implementation -Focus groups on app and dashboard	-Participate in training for outcomes measurement and app implementation -Support access to stakeholders for feedback -Provide feedback during interviews -Participate in fidelity interviews	-Provide feedback and report problems to evaluation team

(YEAR 3: period 2)				
Evaluation Team			EP program providers	County Staff
Program	County	Qualitative		
-Prospective data collection begins in 5 EP programs	-Identify and resolve problems for county-level data for statewide analysis	Barriers/facilitators to implementation -Interviews with EP stakeholders about data collection experience thus far	-Support access to stakeholders for feedback -Ongoing use of app and issue reporting -Provide feedback during interviews	-Assist county-level research collaborators in identifying and resolving issues -Provide feedback during interviews

(YEAR 4: period 1)				
Evaluation Team			EP program providers	County Staff
Program	County	Qualitative		
-Prospective data collection in 5 EP programs - Post-LHCN implementation questionnaires	-Support infrastructure and access to next round of data	-Interviews with EP stakeholders about experience in EP treatment programs	-Support access to stakeholders for feedback -Ongoing use of app and issue reporting -Provide feedback during interviews	-Assist county-level research collaborators in identifying and resolving issues -Provide feedback during interviews
(YEAR 4: period 2)				
Evaluation Team			**EP program providers**	**County Staff**
Program	**County**	**Qualitative**		
-Prospective data collection in 5 EP programs -Post-LHCN implementation questionnaires	-Obtain and analyze second round of county-level data for preliminary 5-county integrated evaluation (EP/CG programs)	-Analyze data from focus groups and stakeholders	-Support access to stakeholders for feedback -Ongoing use of app and issue reporting -Provide feedback during interviews	-Send second round of data for 5 EP Programs -Provide feedback during interviews
(YEAR 5: period 1)				
Evaluation Team			**EP program providers**	**County Staff**
Program	**County**	**Qualitative**		
-Prospective data collection in 5 EP programs	-Continue obtaining and analyzing county-level data for preliminary 5-county integrated evaluation (EP/CG programs)	-Presentation of findings; summary of experiences and feedback from all stakeholders	-Support access to stakeholders for feedback -Ongoing use of app and issue reporting -Provide feedback during interviews	-Send second round of data for 5 EP Programs -Provide feedback during interviews
(YEAR 5: period 2)				
Evaluation Team			**EP program providers**	**County Staff**
Program	**County**	**Qualitative**		
-Obtain and analyze program-level outcomes data collected from Year 3 Period 2 to Year 5 Period 1	-Continue analyzing county-level data for preliminary 5-county integrated evaluation (EP/CG programs)	-Presentation of findings; summary of experiences and feedback from all stakeholders	-Support access to stakeholders for feedback -Ongoing use of app and issue reporting -Provide feedback during interviews	-Provide feedback during interviews

Alignment with Mental Health Services Act General Standards

This project involves:

1. Multi-county collaboration to create a Learning Health Care Network (LHCN) software application.

2. Inclusion of consumers and families throughout the development and evaluation process to enhance the EP programs across the state and support services that are wellness, recovery and resilience-focused
3. Incorporation of consumer-level data into everyday clinical services to enhance their integration within the service delivery system.
4. System improvement measured by quantitative and qualitative research methods and a phased approach will check for utility and plan for sustainability upheld by counties in the long-term, thereby maximizing all available resources for mental health services.
5. Tested using a robust multifaceted evaluation framework, supported by experts in early psychosis program implementation and services research as well as health economics.

Cultural Competence and Stakeholder Involvement in Evaluation

Through our prior project and the development of the current project, we have worked to engage diverse stakeholders across all areas, including consumers served by EP programs and their families, the leadership and clinical providers within EP programs, county and state leadership, as well as community organizations (e.g. NAMI, MHA). Meaningful stakeholder engagement has helped to create the proposed county collaborative LHCN and the associated evaluation. To date, stakeholders have influenced the structure of the LHCN, outcomes to be included, and the evaluation approach. The qualitative component of the proposed project seeks to continue stakeholder engagement throughout the 5-year proposed project, both in the forms of gathering insights and input – as well as helping to interpret the information that is learned.

California's EP programs serve a diverse community and we anticipate that our stakeholders will continue to guide us on how best to serve their communities. Individual partner counties have included diverse community members in their planning processes. For example, Los Angeles County sought feedback on this project on two separate occasions from the System Leadership Team, the Los Angeles County Department of Mental Health's systemic stakeholder body with representatives from diverse communities and stakeholders throughout Los Angeles county. Solano County has held multiple comprehensive community stakeholder processes that have included input from a diverse representation of stakeholders including consumers, family members, mental health and physical health providers, law enforcement, community organizations, educational community, veterans, and representatives from the County's unserved/underserved Latino, Filipino and the LGBTQ communities.

During the proposed project, we will reach out to engage diverse communities to ensure representation on our Advisory Committee, including underserved minorities in terms of race, ethnicity, sex, gender identity, sexual orientation, disability status and immigration/documentation status, among others. A standing agenda item of both project leadership and Advisory Committee meetings will be to ensure that this project is culturally sensitive and responsive. For example, the proposed measures for the LHCN come in a variety of languages and these will be available for consumers and their family members who are participating in the project. Data will be collected on consumer and family member perceptions of the cultural responsiveness of EP programs. Consumer demographic data will be collected to allow for analyses such as comparison to county demographics, and to identify difficulties with access or engagement in EP services that may disproportionally affect minority groups. In a recent survey we conducted with EP programs and county leadership across the state, 13 of 21 stakeholders identified additional training in culturally informed services as a current need. Thus, we expect the collaborative learning meetings between the programs involved in this project will also address challenges and best practices in providing culturally responsive services.

Innovation Project Sustainability and Continuity of Care

A primary goal of the project will determine estimates of the cost and staff time required for the technology-based LHCN. These estimates will inform costs for ongoing participation of EP programs in the LHCN, and to inform allocation of necessary resources from non-INN funds, such as PEI funds, and to encourage new counties to join the LHCN. Overall, we will work to develop a plan to sustain and enhance the web-based LHCN via ongoing funding through contracts with the EP programs and their associated counties, and to add new counties in the next phase.

Second, information from the LHCN will be used to develop training and technical assistance for the affiliated counties, enabling participants to develop new approaches through a learning collaborative, join together for larger trainings, or seek consultation from programs who have developed approaches that yield positive outcomes. In the recent survey of EP programs and county leadership across the state, 11 of 21 stakeholders reported that they have ongoing funding available for training and technical assistance, suggesting an additional avenue for supporting the LHCN.

Finally, individuals with serious mental illness (SMI) who receive services from California's EP programs will continue to do so regardless of whether the LHCN is continued or the program reverts to previous methods for consumer assessment and program evaluation.

Communication and Dissemination Plan

We will communicate the results of this project in a variety of ways:

1. Results of the evaluation will be communicated with stakeholders via webinars, 1-page briefs, or larger presentations based on the needs of the stakeholders. The UC Davis-led team will assist stakeholders in developing their own presentations of the project findings for local groups (e.g. via presentations or newsletters).
2. Findings from the qualitative component will be disseminated via webinars or conference calls to support the learning collaborative of EP programs who are participating in the project.
3. Results of the evaluation will also be published in peer-reviewed academic journals or presented at conferences to share our findings with the larger community.
4. Annual reports will be shared with the MHSOAC and other county or state groups.
5. Products from this project (e.g. webinars, written products, presentations) will be available on the UC Davis Behavioral Health Center of Excellence website.

Project Keywords:

Early Psychosis, County Collaborative, learning health care network, measurement-based care, evidence based practice

Project Update – Initiation through January 2024

The following section of the LHCN Innovation proposal seeks to provide an interim project update, including details on project progress to date, lessons learned, and continued derived benefit from programs joining the multi-county learning collaborative at this later stage of the project.

LHCN Innovation Multi-County Project Progress

Over the past five years of implementing the LHCN in several county early psychosis programs, we've made significant progress in all proposed components of the original proposed project, including the qualitative, program-level, and county-level components of the LHCN. Please see each section below for a brief summary of progress to date in each of these components, as well as a summary of lessons learned from implementing the LHCN thus far.

<u>Qualitative Components of LHCN</u>

The qualitative component of this project is comprised of two distinct phases: the first focused on soliciting input from service users, family members, providers, and county leadership to support the co-design of the LHCN approach. The second focused on engaging with community partners to understand provider and service user experiences of integrating LHCN and the measurement-based care approach into early psychosis services. The primary aims of the interviews were to identify effective facilitators and solutions to barriers to improve project implementation, and evaluate the feasibility, acceptability, and impact of delivering early psychosis care within a learning health care environment.

During the design phase, focus groups held in English and Spanish were conducted to support a co-design approach to the development of the assessment battery, data sharing procedures, and the creation of the data collection and presentation application (Beehive). During the implementation and evaluation phase, provider and service user interviews were conducted to identify barriers and facilitators to effective implementation, with findings iteratively fed back to the implementation team to inform program delivery.

To date, 34 interviews and 40 focus groups including 284 providers, service users, and family members have been completed across 15 EP programs. In the outcomes focus groups functioning, quality of life, recovery, and symptoms of psychosis were identified as key domains to assess in EP care. Participants emphasized the clinical utility of predictors of outcomes, and the importance of concrete, client reported measures. In the focus groups concerning data sharing priorities, participants reported being receptive to data sharing, but exhibited concerns regarding third-party sharing, risk of breaches, and hidden motives in user legal agreements. Increased user-level control for data, and an understandable, transparent EULA was considered key to mitigating concerns. In focus groups supporting Beehive development, participants suggested adding program demographic visualizations, modifications to the registration process to reduce service user burden, and aesthetic changes to make the tool look less "clinical".

In the refining and evaluation stages of the project, interviews with EP program providers and service users identified numerous benefits to Beehive and the adoption of measurement-based care in early psychosis settings. However, substantial variability in both in the feasibility of implementation, and the perception of the benefits and drawbacks of adopting such an approach was found. These findings highlight the importance of exploring the barriers and facilitators to effective implementation to identify and potentially address some of the causes of this variability.

Beehive Implementation
Prior to collecting outcomes data in each participating program, programs need to engage with our team to complete training activities needed to implement Beehive in participating early psychosis (EP) programs. To date, 17 EP programs have completed the full Beehive training series, with a total of 21 completing at least some of the Beehive training series. Once Part 1 Beehive training is completed, programs can initiate enrollment of their clients in Beehive and begin data collection on the outcome surveys. As of October 27, 2023, those 21 EPI-CAL clinics have registered 835 clients in Beehive. Of those 835 clients who have been registered, 65% (n=548) have completed their Beehive end user license agreement (EULA) and are considered to be enrolled in Beehive. Of those who have completed their EULA, 82% (n=452) have agreed to share their de-identified data with NIH and 87% percent (n=479) have agreed to share their de-identified data with UCD.

When examining current enrollment against program census data, we have found that here is quite a bit of variability across programs in the proportion of the program's census that are enrolled in Beehive (mean = 55%, range = 0-166%). There is also extensive variability in the number of PSPs enrolled in Beehive across the programs as well (mean = 31%, range = 0-100%). Four of the participating programs meet or exceed the previously defined benchmark of 50% of PSPs enrolled in Beehive.

Of the 548 clients who have been enrolled in Beehive, 92% (n = 505) have completed at least one survey in Beehive. Now that there are a sufficient number of clients, staff, and primary support persons completing longitudinal surveys, we have begun preliminary analyses of Beehive outcomes data, including detailed analyses on client self-report symptoms, education, employment, and social activities and the relationship to quality of life, medication taking behavior, adverse childhood experiences, substance use, family functioning, and childhood poverty.

Fidelity Assessments
As described in this proposal, we've planned to conduct a fidelity assessment with each participating EP program in the LHCN. The majority of participating programs serve clients with both clinical high-risk syndrome (CHR) in addition to first episode psychosis (FEP). Therefore, most fidelity assessments were conducted using the First Episode Psychosis Services – Fidelity Scale (FEPS-FS) version 1.1 and a pilot version of the Clinical High Risk for Psychosis Services – Fidelity Scale (CHRPS-FS) (Addington, 2021). To date, we have completed assessments in 20 programs. Thirteen provide services for both FEP and CHR clients, four serve FEP only, and three serve clinical high risk only. Some of the assessed programs are well-established programs, but others are new and haven't even seen their first client yet. As a result, they do not have the sufficient service data to complete the health record abstraction necessary for the full fidelity assessment. In those cases, either formative assessments or quality improvement (QI) assessments were conducted in cases where there were insufficient health record data to do a formal assessment.

For both FEPS and CHRPS, the full assessment was possible in the majority of programs. Amongst those where a full or formative assessment could be conducted, the mean FEPS-FS score was 3.86 out of 5. Figure 19 shows a breakdown of the proportion of programs meeting good to high fidelity by each FEPS-FS item. With the CHRPS, mean scores were slightly higher at 3.96 out of 5.

County Data Analysis
As described earlier in this proposal, the County Data evaluation of the LHCN project examines the services and costs associated with individuals treated in Early Psychosis (EP) programs across several California counties in comparison to the services and associated costs for a comparator group (CG) of similar individuals treated in other outpatient clinics. The primary goal of this component is to provide a preliminary demonstration of the proposed method for accessing data

regarding EP programs and CG groups across California. The secondary goal was to analyze service utilization and costs associated with those services across counties. Thus far, in each county we identified an early psychosis (EP) group consisting of individuals served by the early psychosis program. We also identified a comparator group (CG), consisting of individuals with EP diagnoses, within the same age group, who entered standard care outpatient programs during that same time period. The counties participating in this component are Los Angeles, San Diego, Solano, Orange, Napa, Stanislaus, Lake, and Kern counties. The data evaluation has two phases: 1) the three years prior to the start of this project (e.g., January 1st, 2017 – December 31st, 2019) to harmonize data across counties and to account for potential historical trends and 2) for the 2.5-year period contemporaneous with the prospective EP program level data collection (January 1st, 2020 – June 30th, 2022). These dates have been adjusted since our initial proposal.

At this time, we have completed a preliminary multicounty integrated analysis for the retrospective period. This multicounty analysis is based on data provided by Los Angeles, Orange, and San Diego counties. These were counties that had executed contracts and were able to provide us data in time for this analysis. The other counties are in the process of providing their data to our team. We used administrative data to identify youth aged 12 to 25 years who (1) were enrolled in a specialized early psychosis (EP) program from January 2017 to July 2021, and (2) received a first diagnosis of psychosis within one year prior to enrollment. We shared lists of EP youth with program staff who confirmed that these were past or current clients who received their first diagnosis of psychosis. We identified a comparison group (CG) of youth with a first diagnosis of psychosis who received at least one outpatient service during the study period, also within one year of receiving their first diagnosis of psychosis. We excluded youth with a diagnosis of psychosis in more than two years before starting outpatient services, youth with private insurance, and youth who received a diagnosis of intellectual disability (ICD-10 codes F70-F79, ICD-9 codes 317-319). Our preliminary results from this analysis show that youth enrolled in EP programs had a greater number of outpatient mental health visits and higher costs than a comparable group of youth who were receiving services in standard outpatient programs in both the first and second years following the initial diagnosis of psychosis. Youth in EP programs had a lower probability of psychiatric inpatient admission than CG youth in the year following diagnosis. However, there was no significant difference in the number of inpatient days. We did not find significant differences in psychiatric admissions or inpatient days in the second year following diagnosis, nor did we find significant differences in inpatient costs in either year.

Lessons Learned

As noted above in the qualitative and Beehive implementation sections of this summary, there is quite a bit of heterogeneity in the ability of programs to implement the LHCN. This can be due to several factors, including but not limited to lack of perceived benefit, high staff turnover, and contracting delays. We've also experienced significant challenges due to the COVID-19 pandemic, which began one year into implementing the LHCN in California. The pandemic has had lasting effects on all participating California EP programs; most programs have not recovered to their full program capacity in the wake of the lasting effects of a global pandemic on the economy, mental health workforce, and clients seeking care. Programs have been trying to meet client needs even with several staff vacancies, and the lower client census numbers have reflected a reduced workforce. Even so, the EP programs have been great partners with our team in implementing the LHCN and actively contribute to problem-solving. For example, they continue to participate in qualitative interviews, as summarized above, to help provide insight on what is working well, and meet regularly with our team to address any active issues or challenges in real-time. Our team has learned that we cannot take a one-size-fits-all approach to implementation, and we must prioritize the input from programs in order to resolve issues rather than a standalone, top-down approach. While this approach has been effective, we've also learned that it takes quite a bit of time to implement in this manner. Additionally, this partnered

approach and the structure of the LHCN doesn't allow our team to enforce consequences if objectives aren't met in a timely manner.

Continued Benefits of Joining LHCN

The current revised proposal submission was initiated with Ventura County wanting to join the existing Learning Health Care Network. While at this stage programs will not be able to have input on the battery of outcomes to be collected or the initial design of the application, there are benefits to joining the project at this later stage. For example, counties joining at this later stage are joining at a time where the application for data collection, Beehive, has already been developed and data collection is active and ongoing. Therefore, new LHCN programs are able to hit the ground running with data collection and do not have to wait for the development stage of the project to transpire. In addition, our training approach to implementing Beehive in EP programs in well-established. We have refined our training approach over the years from continuous feedback on what works and what doesn't, and now administer both synchronous and asynchronous training materials to programs so that all staff members have an opportunity to participate in the LHCN data collection. Our team is starting detailed analysis on outcomes and what components of care influence client outcomes, and new programs joining the LHCN will be able to benefit from that information from the large statewide dataset to inform clinical practice in their own clinics. In summary, counties and their EP programs joining at a later stage of the project are benefitting from an established infrastructure.

In addition to the benefits to the program to joining an established Learning Health Care Network, the LHCN itself benefits from additional programs joining. There are more programs contributing data to the harmonized dataset, and the clients in each of the programs are unique to their region of California. For example, Ventura County is a diverse county with a well-established early intervention program with a large client base.

LHCN Budget Narrative for County INN funds

Personnel

The total personnel cost for the county portion of the evaluation and learning health care network component at UC Davis is $1,070,474 over 6 fiscal years. This includes $759,074 for salaries and $311,400 for fringe benefits.
Personnel will include:

- Tara Niendam, Ph.D. The PI of the project with part time effort for the duration of the project.
- Joy Melnikow, M.D., M.PH., co-investigator with an expertise in health care policy, research, and cost effectiveness evaluation with part time effort for the duration of the project.
- Laura Tully, Ph.D., co-investigator with expertise in mobile health platforms and clinical training with part time effort for the duration of the project.
- Valerie Tryon, Ph.D. A project coordinator with part time effort for the duration of the project.
- Guibo Xing, Ph.D., biostatistician with part time effort for the duration of the project.
- Jessica Hicks, An administrative director with part time effort for the duration of the project.
- TBN, A postdoctoral researcher with part time effort for the duration of the project.
- TBN, A data manager with part time effort for the duration of the project.
- TBN, A research administrator with part time effort.
- TBN, One full-time research assistants for years 2-5.
- TBN, One part-time research assistants for years 3-4.

The personnel costs include a 3% annual salary escalation for cost-of-living increases. Fringe benefits are calculated using UC Davis' federally negotiated rate agreement. Rates are applied by title code and fiscal year.

Supplies

The total cost for supplies will be $63,725. This will include project supplies handheld tablet devices for each of the sites including replacements (4 devices per site, 13 sites, 3 to 4 replacements total per year over 5 years, computers for project staff, software for project staff, stakeholder meeting costs, mobile hotspot subscription for half of project sites, and translation services.

Travel

Travel costs will total $47,750 over the course of the project. The majority of travel costs are for site visits over 5 years. Travel for consultants is also included for Years 1-6. The remaining travel costs will go toward conference travel for dissemination of results for Years 2-6.

Subcontracts

The project budgets for two subcontracts, one with UCSF and one with UCSD, and subcontract costs will total $2,470,446. For UCSF, their total cost ($1,259,948) is broken down into costs for personnel salaries, fringe benefits, travel, and supplies. Personnel include two co-investigators (Rachel Loewy, Ph.D. and Mark Savill, Ph.D.), and a part-time clinical research coordinator. For UCSD, their total cost ($1,210,499) is broken down into costs for personnel salaries, fringe benefits, travel, and supplies. Personnel include a co-investigator, a field researcher, a postdoctoral researcher, and a biostatistician.

Consultation

The budget includes costs of multiple consultants. The first is Don Addington, M.D. from University of Calgary. He will provide expertise on fidelity assessment. The second consultant is Sonya Gabrielian, M.D. from UCLA. She will provide consultation on risk factors for homelessness. We will also hire Quorum Technologies, an outside company, for application development and support in Years 1-6..

These costs to Quorum Technologies will include consultation to provide guidance in the development of the app's user interface to improve the consumer and provider experience with the app.

Other Costs
Other costs will include subject and staff payments for taking surveys. We will pay 5 clients and 5 staff at 5 sites for Years 1-6. We will also include funds for an annual executive meeting of all personnel and consultants.

Indirect Costs
Indirect costs are calculated at the MHSOAC's published rate of 15% of Total Cost, totaling $355,728.

Total Cost
The total cost for the LHCN Budget from County INN funding will be $4,841,967.

LHCN Budget from County INN funding - All Counties

BUDGET CONTEXT - EXPENDITURES BY FUNDING SOURCE AND FISCAL YEAR (FY)								
EXPENDITURES								
		1/1/19-6/30/19	**7/1/19-6/30/20**	**7/1/20-6/30/21**	**7/1/21-6/30/22**	**7/1/22-6/30/23**	**7/1/23-12/31/23**	**1/1/19-12/31/23**
PERSONNEL COSTS (salaries, wages, benefits)		**FY 18/19 (6 mo)**	**FY 19/20 (12 mo)**	**FY 20/21 (12 mo)**	**FY 21/22 (12 mo)**	**FY 22/23 (12 mo)**	**FY 23/24 (6 mo)**	**TOTAL**
1.	Salaries	$46,082	$144,890	$161,809	$158,828	$160,600	$86,865	$759,074
2.	Benefits	$16,915	$56,198	$64,806	$65,324	$69,429	$38,728	$311,400
3.	Indirect Costs	$11,117.12	$35,486.12	$39,990.88	$39,556.24	$40,593.35	$22,163.47	$188,907
4.	Total Personnel Costs	$74,114	$236,574	$266,606	$263,708	$270,622	$147,756	$1,259,381
OPERATING COSTS		**FY 18/19 (6 mo)**	**FY 19/20 (12 mo)**	**FY 20/21 (12 mo)**	**FY 21/22 (12 mo)**	**FY 22/23 (12 mo)**	**FY 23/24 (6 mo)**	**TOTAL**
5.	Direct Costs							
6.	Indirect Costs							
7.	Total Operating Costs							
NONRECURRING COSTS (equipment, technology)		**FY 18/19 (6 mo)**	**FY 19/20 (12 mo)**	**FY 20/21 (12 mo)**	**FY 21/22 (12 mo)**	**FY 22/23 (12 mo)**	**FY 23/24 (6 mo)**	**TOTAL**
8a.	Direct Costs (Supplies)	$21,988	$11,650	$10,650	$7,775	$7,775	$3,888	$63,725
8b.	Direct Costs (Travel)	$1,250	$9,250	$11,500	$10,750	$7,250	$7,750	$47,750
8c.	Direct Costs (Other)	$250	$1,500	$250	$1,500	$250	$250	$4,000
9.	Indirect Costs	$4,144.85	$3,952.94	$3,952.94	$3,533.82	$2,695.59	$2,097.79	$20,378

10.	Total Operating Costs	$27,632	$26,353	$26,353	$23,559	$17,971	$13,985	$135,853
CONSULTANT COSTS/ CONTRACTS (clinical training, facilitator, evaluation)		**FY 18/19 (6 mo)**	**FY 19/20 (12 mo)**	**FY 20/21 (12 mo)**	**FY 21/22 (12 mo)**	**FY 22/23 (12 mo)**	**FY 23/24 (6 mo)**	**TOTAL**
11a.	Direct Costs (Subawards)	$243,006	$467,826	$491,294	$498,043	$517,660	$252,617	$2,470,446
11b.	Direct Costs (Consultant)	$344,657	$262,938	$96,156	$79,063	$31,656	$15,375	$829,844
12.	Indirect Costs	$60,821.74	$46,400.74	$16,968.75	$13,952.21	$5,586.40	$2,713.24	$146,443
13.	Total Consultant Costs	$648,484	$777,164	$604,419	$591,058	$554,902	$270,705	$3,446,733
OTHER EXPENDITURES (please explain in budget narrative)		**FY 18/19 (6 mo)**	**FY 19/20 (12 mo)**	**FY 20/21 (12 mo)**	**FY 21/22 (12 mo)**	**FY 22/23 (12 mo)**	**FY 23/24 (6 mo)**	**TOTAL**
14.								
15.								
16.	Total Other Expenditures							
BUDGET TOTALS:								
Personnel (salaries and benefits)		$62,997	$201,088	$226,615	$224,152	$230,029	$125,593	$1,070,474
Direct Costs (consultation, nonrecurring costs)		$611,150	$753,163	$609,851	$597,131	$564,591	$279,879	$3,415,765
Indirect Costs (15% TC)		$76,084	$85,840	$60,913	$57,042	$48,875	$26,975	$355,728
TOTAL INNOVATION BUDGET		**$750,230**	**$1,040,091**	**$897,378**	**$878,325**	**$843,495**	**$432,447**	**$4,841,967**

One Mind Grant Budget Narrative

Personnel

The total personnel cost for the One Mind portion of the evaluation and learning health care network component at UC Davis is $1,013,947 over 6 fiscal years. This includes $719,579 for salaries and $294,368 for fringe benefits.

Personnel will include:

- Tara Niendam, Ph.D. The PI of the project with part time effort for the duration of the project.
- Joy Melnikow, M.D., M.PH., co-investigator with an expertise in health care policy, research, and cost effectiveness evaluation with part time effort for the duration of the project.
- Laura Tully, Ph.D., co-investigator with expertise in mobile health platforms and clinical training with part time effort for the duration of the project.
- Valerie Tryon, Ph.D. A project coordinator with part time effort for the duration of the project.
- Guibo Xing, Ph.D., biostatistician with part time effort for the duration of the project.
- Jessica Hicks, An administrative director with part time effort for the duration of the project.
- Rebecca Grattan, Ph.D. A postdoctoral researcher with part time effort for the duration of the project.
- TBN, A data manager with part time effort for the duration of the project.
- TBN, A research administrator with part time effort.
- TBN, One full-time research assistants for years 2-5.
- TBN, One part-time research assistants for years 3-4.

The personnel costs include a 3% annual salary escalation for cost-of-living increases. Fringe benefits are calculated using UC Davis' federally negotiated rate agreement. Rates are applied by title code and fiscal year.

Supplies

The total cost for supplies will be $63,725. This will include project supplies, handheld tablet devices for each of the sites including replacements (4 devices per site, 13 sites, 3 to 4 replacements total per year over 5 years), computers for project staff, software for project staff, stakeholder meeting costs (not including travel), mobile hotspot subscription for half of project sites, and translation services.

Travel

Travel costs will total $47,750 over the course of the project. The majority of travel costs are for site visits over 5 years. Travel for consultants is included for Years 1-6. The remaining travel costs will go toward conference travel for dissemination of results for Years 2-6.

Consultation

The budget includes costs of multiple consultants. The first is Don Addington, M.D. from University of Calgary. He will provide expertise on fidelity assessment. The second consultant is Sonya Gabrielian, M.D. from UCLA. She will provide consultation on risk factors for homelessness. We will also hire Quorum Technologies, an outside company, for application development and support in Years 1-6These costs to Quorum Technologies will include consultation to provide guidance in the development of the app's user interface to improve the consumer and provider experience with the app.

Other Costs

Other costs will include subject and staff payments for taking surveys. We will pay 5 clients and 5 staff at 5 sites for Years 1-6. We will also include funds for an annual executive meeting of all personnel and consultants.

Indirect Costs

Indirect costs are calculated at the One Mind Foundation's published rate of 10% of Total Direct Costs, totaling $136,364.

Total Cost

The total cost for the LHCN Budget from County INN funding will be $1,500,000.

LHCN Budget from One Mind Grant

BUDGET CONTEXT - EXPENDITURES BY FUNDING SOURCE AND FISCAL YEAR (FY)								
EXPENDITURES								
		1/1/19-6/30/19	**7/1/19-6/30/20**	**7/1/20-6/30/21**	**7/1/21-6/30/22**	**7/1/22-6/30/23**	**7/1/23-12/31/23**	**1/1/19-12/31/23**
PERSONNEL COSTS (salaries, wages, benefits)		**FY 18/19 (6 mo)**	**FY 19/20 (12 mo)**	**FY 20/21 (12 mo)**	**FY 21/22 (12 mo)**	**FY 22/23 (12 mo)**	**FY 23/24 (6 mo)**	**TOTAL**
1.	Salaries	$43,318	$138,061	$155,459	$149,477	$150,242	$83,022	$719,579
2.	Benefits	$16,025	$52,853	$62,162	$61,922	$64,797	$36,609	$294,368
3.	Indirect Costs	$5,934.30	$19,091.40	$21,762.10	$21,139.90	$21,503.90	$11,963.10	$101,395
4.	Total Personnel Costs	$65,277	$210,005	$239,383	$232,539	$236,543	$131,594	$1,115,342
OPERATING COSTS		**FY 18/19 (6 mo)**	**FY 19/20 (12 mo)**	**FY 20/21 (12 mo)**	**FY 21/22 (12 mo)**	**FY 22/23 (12 mo)**	**FY 23/24 (6 mo)**	**TOTAL**
5.	Direct Costs							
6.	Indirect Costs							
7.	Total Operating Costs							
NONRECURRING COSTS (equipment, technology)		**FY 18/19 (6 mo)**	**FY 19/20 (12 mo)**	**FY 20/21 (12 mo)**	**FY 21/22 (12 mo)**	**FY 22/23 (12 mo)**	**FY 23/24 (6 mo)**	**TOTAL**
8a.	Direct Costs (Supplies)	$21,988	$11,650	$10,650	$7,775	$7,775	$3,888	$63,725
8b.	Direct Costs (Travel)	$1,250	$9,250	$11,500	$10,750	$7,250	$7,750	$47,750
8c.	Direct Costs (Other)	$200	$1,551	$250	$1,501	$250	$250	$4,001
9.	Indirect Costs	$2,343.75	$2,245.05	$2,240.00	$2,002.55	$1,527.50	$1,188.75	$11,548
10.	Total Operating Costs	$25,781	$24,696	$24,640	$22,028	$16,803	$13,076	$127,024

CONSULTANT COSTS/ CONTRACTS (clinical training, facilitator, evaluation)		FY 18/19 (6 mo)	FY 19/20 (12 mo)	FY 20/21 (12 mo)	FY 21/22 (12 mo)	FY 22/23 (12 mo)	FY 23/24 (6 mo)	TOTAL
11a.	Direct Costs (Subawards)	$0	$0	$0	$0	$0	$0	$0
11b.	Direct Costs (Consultant)	$53,584	$59,363	$32,706	$41,303	$42,413	$4,845	$234,213
12.	Indirect Costs	$5,358.35	$5,936.25	$3,270.63	$4,130.25	$4,241.33	$484.50	$23,421
13.	Total Consultant Costs	$58,942	$65,299	$35,977	$45,433	$46,655	$5,330	$257,634
OTHER EXPENDITURES (please explain in budget narrative)		**FY 18/19 (6 mo)**	**FY 19/20 (12 mo)**	**FY 20/21 (12 mo)**	**FY 21/22 (12 mo)**	**FY 22/23 (12 mo)**	**FY 23/24 (6 mo)**	**TOTAL**
14.								
15.								
16.	Total Other Expenditures							
BUDGET TOTALS:								
Personnel (salaries and benefits)		$59,343	$190,914	$217,621	$211,399	$215,039	$119,631	$1,013,947
Direct Costs (consultation, nonrecurring costs)		$77,021	$81,813	$55,106	$61,328	$57,688	$16,733	$349,689
Indirect Costs (10% TDC)		$13,636	$27,273	$27,273	$27,273	$27,273	$13,636	$136,364
TOTAL INNOVATION BUDGET		**$150,000**	**$300,000**	**$300,000**	**$300,000**	**$300,000**	**$150,000**	**$1,500,000**

Appendix I: Los Angeles County

County Contact and Specific Dates

- Primary County Contact (Name, Email, Phone):
  Debbie Innes-Gomberg, Ph.D.
  DIGomberg@dmh.lacounty.gov
  (213)738-2756

- Date Proposal posted for 30-day Public Review:
  AB114 Plan posted March 23, 2018 - April 21, 2018
  Innovation 8 posted August 14, 2018 – September 12, 2018

- Date of Local MH Board hearing:
  System Leadership Team presentations: January 17, 2018, April 18, 2018 and June 20, 2018
  Mental Health Commission presentation: June 28, 2018

- Date of BOS approval or calendared date to appear before BOS:
  AB114 plan approved June 6, 2018

Description of the Local Need

Los Angeles County is the largest in California with over 10 million residents. In Fiscal Year 2016-2017, LACDMH served an estimated 460,624 consumers. About 15% of those served in Calendar Year 2016 were diagnosed with a psychotic disorder. Given the population density of Los Angeles County, an effective Early Psychosis program with evidenced-based components and outcomes monitoring can have a positive impact on the well-being of a significant number of consumers. Los Angeles County, through its MHSA Prevention and Early Intervention (PEI) plan, implemented an early psychosis program developed through the UCLA Center for the Assessment and Prevention of Prodromal States (CAPPS). While the program to date has provided a full course of services to 186 clients (representing 43% of those who started the practice) and achieved a 30% improvement in mental health functioning and a 60% reduction in prodromal symptoms, a portion of the provider cohort reduced or eliminated their use of the practice and the developer moved the center to the East Coast.

As part of a comprehensive review and addition to the Department's PEI plan contained in the MHSA 3 Year Program and Expenditure Plan for Fiscal Years 2018-18 through 2019-20, there was a plan to increase early psychosis services. After a comprehensive review of evidence-based coordinated specialty care models, the Department selected the Portland Identification and Early Referral (PIER) model. The Department issued a solicitation for five contracted programs on June 29, 2018 and has identified two directly operated programs for a total of seven teams that will implement the PIER model.

Through this Innovation proposal, LACDMH proposes to participate in a learning health care network that will aid in the consistent and successful implementation and sustainment of coordinated specialty care early psychosis services within Los Angeles County.

Description of the Response to the Local Need

By participating in the learning health care network, LACDMH seeks to enhance learning on the most effective engagement and treatment approaches in order to decrease the duration of untreated psychosis and optimize early detection. Utilizing data collected during the course of this project will improve and enhance the newly-expanded EP program by identifying the EP program components

associated with client-level outcomes in particular domains of functioning, identifying what program components lead to more or less utilization (e.g. hospitalization) and to what extent fidelity to evidenced-based care relates to client-level outcomes.

Cultural & Linguistic Competency
The threshold languages in Los Angeles County are Arabic, Armenian, Cambodian/Khmer, Cantonese, Farsi, Korean, Mandarin, Other-Chinese (for purposes of written communication, Chinese includes Traditional and Simplified Chinese), Russian, Spanish, Tagalog, and Vietnamese.
Given the cultural and linguistic diversity of Los Angeles County, identifying effective program components for addressing the needs of diverse populations throughout California will help LACDMH implement EP services that will reach more families and more communities. Data collected about client-level outcomes will help determine if particular communities are being appropriately served by the program components provided.

LACDMH twice reviewed this project with the System Leadership Team, the Department's systemic stakeholder body with representatives from diverse communities and stakeholders throughout Los Angeles County.

Through University of California - Davis' (UCD) prior project and the development of the current project, they have worked to engage stakeholders across all areas, including clients served by EP programs and their families, the leadership and clinical providers within EP programs, county and state leadership, as well as community organizations (e.g. NAMI). Meaningful stakeholder engagement has helped to create the proposed county collaborative Learning Health Care Network (LHCN) and the associated evaluation. To date, stakeholders have influenced the structure of the LHCN, outcomes to be included, and the evaluation approach. The Qualitative component of the proposed project seeks to continue stakeholder engagement throughout the 3-year proposed project, both in the forms of gathering insights and input – as well as helping to interpret the information learned. California's EP programs serve diverse communities and we anticipate that our stakeholders will guide us on how best to serve their community. For example, the proposed measures for the LHCN come in a variety of languages and these will be available for both clients and their family members who are participating in the project.

Description of the Local Community Planning Process
This project was publically posted on March 23, 2018 as part of the Department's AB 114 spending plan for Innovation funding. No public comment was received as part of that public posting. The Los Angeles County Board of Supervisors adopted the AB 114 spending plan, along with the MHSA Fiscal Year 2018-19 Annual Update on June 6, 2018.

LACDMH reviewed this project with the System Leadership Team, the Department's systemic stakeholder body on January 17, 2018, April 18, 2018 and June 20, 2018. LACDMH also reviewed this project with the Los Angeles County Mental Health Commission on June 28, 2018. This project was publically posted again on August 14, 2018 with additional detail added. No public comment was received as part of that public posting.

Total Budget Request by Fiscal Year:
Total budget by fiscal year for the county collaborative portion of the costs.

	FY 18/19 (6 mo)	FY 19/20 (12 mo)	FY 20/21 (12 mo)	FY 21/22 (12 mo)	FY 22/23 (12 mo)	FY 23/24 (6 mo)	TOTAL
Total County Contribution to Collaborative	$565,482	$963,740	$876,102	$864,416	$843,054	$432,233	**$4,545,027**

Budget Narrative for LHCN and Evaluation:
Los Angeles County will adopt the successful practices identified during this project into its Early Psychosis programs. After the completion of this project, the County will attempt to continue to fund staff with Prevention and Early Intervention dollars.

A detailed budget narrative for the entire county collaborative is described above. Los Angeles county is contributing 58% of the funds in the county collaborative for the LHCN and evaluation. This proportion is based off of county size of all participating LHCN counties.

Budget by Fiscal Year and Specific Budget Category for LHCN and Evaluation for Los Angeles County:

BUDGET CONTEXT - EXPENDITURES BY FUNDING SOURCE AND FISCAL YEAR (FY)								
EXPENDITURES								
		1/1/19-6/30/19	**7/1/19-6/30/20**	**7/1/20-6/30/21**	**7/1/21-6/30/22**	**7/1/22-6/30/23**	**7/1/23-12/31/23**	**1/1/19-12/31/23**
PERSONNEL COSTS (salaries, wages, benefits)		**FY 18/19 (6 mo)**	**FY 19/20 (12 mo)**	**FY 20/21 (12 mo)**	**FY 21/22 (12 mo)**	**FY 22/23 (12 mo)**	**FY 23/24 (6 mo)**	**TOTAL**
1.	Salaries	$26,918	$84,634	$94,516	$92,775	$93,810	$50,740	$443,393
2.	Benefits	$9,880	$32,827	$37,855	$38,157	$40,555	$22,622	$181,896
3.	Indirect Costs	$6,494	$20,728	$23,360	$23,106	$23,712	$12,946	$110,345
4.	Total Personnel Costs	$43,292	$138,188	$155,731	$154,038	$158,077	$86,308	$735,634
OPERATING COSTS		**FY 18/19 (6 mo)**	**FY 19/20 (12 mo)**	**FY 20/21 (12 mo)**	**FY 21/22 (12 mo)**	**FY 22/23 (12 mo)**	**FY 23/24 (6 mo)**	**TOTAL**
5.	Direct Costs							
6.	Indirect Costs							
7.	Total Operating Costs							
NONRECURRING COSTS (equipment, technology)		**FY 18/19 (6 mo)**	**FY 19/20 (12 mo)**	**FY 20/21 (12 mo)**	**FY 21/22 (12 mo)**	**FY 22/23 (12 mo)**	**FY 23/24 (6 mo)**	**TOTAL**
8a.	Direct Costs (Supplies)	$12,843	$6,805	$6,221	$4,542	$4,542	$2,271	$37,223
8b.	Direct Costs (Travel)	$730	$5,403	$6,717	$6,279	$4,235	$4,527	$27,892
8c.	Direct Costs (Other)	$146	$876	$146	$876	$146	$146	$2,336
9.	Indirect Costs	$2,421	$2,309	$2,309	$2,064	$1,575	$1,225	$11,903
10.	Total Operating Costs	$16,141	$15,393	$15,393	$13,761	$10,497	$8,169	$79,355
CONSULTANT COSTS/ CONTRACTS (clinical training, facilitator, evaluation)		**FY 18/19 (6 mo)**	**FY 19/20 (12 mo)**	**FY 20/21 (12 mo)**	**FY 21/22 (12 mo)**	**FY 22/23 (12 mo)**	**FY 23/24 (6 mo)**	**TOTAL**

11a.	Direct Costs (Subawards)	$141,945	$273,268	$286,976	$290,919	$302,377	$147,559	$1,443,044
11b.	Direct Costs (Consultant)	$201,322	$153,588	$56,167	$46,182	$18,491	$8,981	$484,731
12.	Indirect Costs	$35,527	$27,104	$9,912	$8,150	$3,263	$1,585	$85,541
13.	Total Consultant Costs	$378,794	$453,959	$353,055	$345,251	$324,131	$158,125	$2,013,316
OTHER EXPENDITURES (please explain in budget narrative)		**FY 18/19 (6 mo)**	**FY 19/20 (12 mo)**	**FY 20/21 (12 mo)**	**FY 21/22 (12 mo)**	**FY 22/23 (12 mo)**	**FY 23/24 (6 mo)**	**TOTAL**
14.								
15.								
16.	Total Other Expenditures							
BUDGET TOTALS:								
Personnel (salaries and benefits)		$36,798	$117,460	$132,371	$130,932	$134,365	$73,362	$625,288
Direct Costs (consultation, nonrecurring costs)		$356,987	$439,940	$356,228	$348,798	$329,791	$163,484	$1,995,227
Indirect Costs (15% TC)		$44,442	$50,141	$35,580	$33,320	$28,549	$15,756	$207,789
TOTAL - Evaluation		**$438,227**	**$607,541**	**$524,179**	**$513,050**	**$492,705**	**$252,602**	**$2,828,304**
Administration of Services		**$21,709**	**$30,382**	**$26,209**	**$25,652**	**$24,635**	**$12,827**	**$141,414**
TOTAL		**$455,885**	**$638,026**	**$550,388**	**$538,702**	**$517,340**	**$269,376**	**$2,969,717**

Budget Narrative for County Specific Needs:

Data Support Person:

The county data person will perform two data pulls during the course of the five-year project. Data will be for EP and comparator program utilization and contracted costs, ED and hospital utilization and costs, and other data as available (e.g. IOP/PHP costs, justice involvement). They will participate in bi-weekly consultation meetings to harmonize data systems and identify variables. It is anticipated that each pull will take 40 hours at two time points (once at the end of Year 2, and once at the end of Year 4).

Years 1-6: .05 FTE in kind

Practice Champion: Supervising Psychologist

The county administrative support person will participate in monthly meetings with the evaluation team as well as biweekly meetings EP and comparator program leadership for problem solving. They would also participate in quarterly meetings with other counties as part of the learning health care network.

Year 1: 0.25 FTE
Years 2-6: 1.0 FTE
Year 6: 0.5 FTE

EP Program Staff

EP Program Manager/Administrator

** 1 per program/site/team**

The program manager will attend monthly project meetings and quarterly learning health care network meetings. They will also meet weekly with program support staff to ensure task completion to meet project goals. They will oversee the fidelity evaluation at their site.
Years 1-6: .05 FTE (Average 2 hrs per week) X 7 teams in LA County = 0.35 FTE in kind

EP Program Support Person/Community Worker:
At County Directly-Operated programs, the program support person will participate in monthly project meetings and weekly meetings with program manager. They will schedule meetings associated with qualitative data collection at their site, including meetings with client/family, program, and county stakeholders. They will provide administrative support for the fidelity evaluation at their site, including scheduling of site meetings and health record abstraction (est. 1 hr per chart for 10 charts). They will the administer tablets to clients 3 times per year, roughly one assessment per day accounting for a 25% no show rate, for every 50 clients.
Year 1: 1.0 FTE
Years 2 – 5: 2.0 FTE
Year 6: 1.0 FTE

Budget by Fiscal Year and Specific Budget Category for County Specific Needs:

	BUDGET BY FISCAL YEAR AND SPECIFIC BUDGET CATEGORY FOR COUNTY SPECIFIC NEEDS							
	EXPENDITURES							
PERSONNEL COSTS (salaries, wages, benefits)		**FY 18/19 (6 mo)**	**FY 19/20 (12 mo)**	**FY 20/21 (12 mo)**	**FY 21/22 (12 mo)**	**FY 22/23 (12 mo)**	**FY 23/24 (6 mo)**	**TOTAL**
1.	Salaries	$109,597	$325,714	$325,714	$325,714	$325,714	$162,857	$1,575,310
2.	Direct Costs							
3.	Indirect Costs							
4.	Total Personnel Costs	$109,597	$325,714	$325,714	$325,714	$325,714	$162,857	$1,575,310
OPERATING COSTS		**FY 18/19 (6 mo)**	**FY 19/20 (12 mo)**	**FY 20/21 (12 mo)**	**FY 21/22 (12 mo)**	**FY 22/23 (12 mo)**	**FY 23/24 (6 mo)**	**TOTAL**
5.	Direct Costs							
6.	Indirect Costs							
7.	Total Operating Costs							
NONRECURRING COSTS (equipment, technology)		**FY 18/19 (6 mo)**	**FY 19/20 (12 mo)**	**FY 20/21 (12 mo)**	**FY 21/22 (12 mo)**	**FY 22/23 (12 mo)**	**FY 23/24 (6 mo)**	**TOTAL**
8								
9.								
10.	Total Non-recurring Costs							
CONSULTANT COSTS/ CONTRACTS (clinical direct service contract)		**FY 18/19 (6 mo)**	**FY 19/20 (12 mo)**	**FY 20/21 (12 mo)**	**FY 21/22 (12 mo)**	**FY 22/23 (12 mo)**	**FY 23/24 (6 mo)**	**TOTAL**
11a.	Direct Costs							
12.	Indirect Costs							
13.	Total Consultant Costs							

OTHER EXPENDITURES (please explain in budget narrative)		**FY 18/19 (6 mo)**	**FY 19/20 (12 mo)**	**FY 20/21 (12 mo)**	**FY 21/22 (12 mo)**	**FY 22/23 (12 mo)**	**FY 23/24 (6 mo)**	**TOTAL**
14.								
15.								
16.	Total Other Expenditures							
	BUDGET TOTALS:							
Personnel (line 1)		$109,597	$325,714	$325,714	$325,714	$325,714	$162,857	$1,575,310
Direct Costs (add lines 2, 5 and 11 from above)								
Indirect Costs (add lines 3, 6 and 12 from above)								
Non-Recurring costs (line 10)								
Other expenditures (line 16)								
TOTAL INNOVATION BUDGET		$109,597	$325,714	$325,714	$325,714	$325,714	$162,857	**$1,575,310**

Budget Narrative for Total Budget Context- Expenditures by Funding Source and Fiscal Year:
All funds for the county collaborative are planned to come from Innovative MHSA funds.

Total Budget Context – Expenditures by Funding Source and Fiscal Year (FY):

	TOTAL BUDGET CONTEXT- EXPENDITURES BY FUNDING SOURCE AND FISCAL YEAR (FY)							
	ADMINISTRATION:							
A.	**Estimated total mental health expenditures for ADMINISTRATION for the entire duration of this INN Project by FY & the following funding sources:**	**FY 18/19 (6 mo)**	**FY 19/20 (12 mo)**	**FY 20/21 (12 mo)**	**FY 21/22 (12 mo)**	**FY 22/23 (12 mo)**	**FY 23/24 (6 mo)**	**TOTAL**
1.	Innovative MHSA Funds	$109,597	$325,714	$325,714	$325,714	$325,714	$162,857	$1,575,310
2.	Federal Financial Participation	0	0	0	0	0	0	0
3.	1991 Realignment	0	0	0	0	0	0	0
4.	Behavioral Health Subaccount	0	0	0	0	0	0	0
5.	Other Funding	0	0	0	0	0	0	0
6.	**Total Proposed Administration**	$109,597	$325,714	$325,714	$325,714	$325,714	$162,857	$1,575,310
	EVALUATION:							
B.	**Estimated total mental health expenditures for EVALUATION for the entire duration of this INN Project by FY & the following funding sources:**	**FY 18/19 (6 mo)**	**FY 19/20 (12 mo)**	**FY 20/21 (12 mo)**	**FY 21/22 (12 mo)**	**FY 22/23 (12 mo)**	**FY 23/24 (6 mo)**	**TOTAL**

1.	Innovative MHSA Funds	$455,885	$638,026	$550,388	$538,702	$517,340	$269,376	**$2,969,717**
2.	Federal Financial Participation	0	0	0	0	0	0	0
3.	1991 Realignment	0	0	0	0	0	0	0
4.	Behavioral Health Subaccount	0	0	0	0	0	0	0
5.	Other Funding	0	0	0	0	0	0	0
6.	**Total Proposed Evaluation**							
	TOTAL:							
C.	**Estimated TOTAL mental health expenditures (this sum to total for funding requested) for the entire duration of this INN Project by FY & the following funding sources:**	**FY 18/19 (6 mo)**	**FY 19/20 (12 mo)**	**FY 20/21 (12 mo)**	**FY 21/22 (12 mo)**	**FY 22/23 (12 mo)**	**FY 23/24 (6 mo)**	**TOTAL**
1.	Innovative MHSA Funds	$565,482	$963,740	$876,102	$864,416	$843,054	$432,233	**$4,545,027**
2.	Federal Financial Participation	0	0	0	0	0	0	0
3.	1991 Realignment	0	0	0	0	0	0	0
4.	Behavioral Health Subaccount	0	0	0	0	0	0	0
5.	Other Funding	0	0	0	0	0	0	0
6.	**Total Proposed Expenditures**	$565,482	$963,740	$876,102	$864,416	$843,054	$432,233	**$4,545,027**

Appendix II: Orange County

County Contact and Specific Dates

- Primary County Contact (Name, Email, Phone): Flor Yousefian Tehrani, fyousefiantehrani@ochca.com; (714) 517-6100
- Date Proposal posted for 30-day Public Review: June 20, 2018
- Date of Local MH Board hearing: July 25, 2018
- Date of BOS approval or calendared date to appear before BOS: January 2019

Description of the Local Need

In Spring 2011, Orange County launched the Orange County Center for Resilience, Education and Wellness (OC CREW), a program that serves youth ages 12 through 25 who are experiencing a first episode of psychotic illness, with symptom onset within the last 24 months.

From its inception to Fiscal Year (FY) 2016-17, OC CREW has served more than 235 participants and noted positive participant and family member outcomes("Orange County Health Care Agency: Mental Health Services Act Three-Year Plan FY 17-18–19/20," 2017). Table 1 provides an overview of the current project evaluation process.

Table 1. OC CREW Participant Outcome Evaluation

Measure	Specification	Assessment	Data Collection
Positive and Negative Symptom Scale (PANSS)	Structured interview	Comprehensive assessment of symptom severity	Intake and every 3 months until program exit
Patient-Reported Outcomes Measurement Information System Global Health	Self-report with both adult and child forms	Evaluation and monitoring of physical, mental, and social health	Intake and every 3 months until program exit
Community Functioning	Participant data	Information gathered during individual and family sessions including number of crisis calls, hospitalization, incarceration, barriers for treatment, school/work attendance, etc.	Monthly

To date, the PANSS is the primary tool used to report OC CREW participant outcomes and assess program impact. Although staff regard the measure as a useful and valid tool, there are several challenges with the current evaluation process:

- Interview with participants takes a minimum of 90 minutes to complete
- Results are manually scored and entered into a data spreadsheet
- Documentation of results may take up to one week, depending on staff workload
- Results are reviewed with participants and families on a case-by-case basis, with very few participants inquiring about their scores

- Observations from psychiatrists indicate that participants struggle with the length of the interview, especially individuals who are highly symptomatic

Orange County seeks to participate in this project in order to: collaborate with other counties to standardize the evaluation of early psychosis programs; establish shared learning; and apply identified strategies that will improve OC CREW participant outcomes, program impact and cost-effectiveness.

Description of the Response to the Local Need

The key priorities outlined in the LHCN Project (i.e., utility of electronic tablet data collection; immediate access to participant-level data; use of measures relevant to participants' experience and real-world outcomes; and cost-effectiveness) will allow Orange County to address the current challenges in its program evaluation process. More specifically, participating in this project and aligning with the identified priorities will enable Orange County to:

- Improve participant data collection and tracking methods
- Provide timely, effective and efficient service delivery
- Allow clinicians easy access to client-level data
- Offer participants the ability to view their data in real-time
- Engage participants in their treatment and recovery

In addition, this project will provide Orange County the opportunity to share and exchange knowledge with other counties about their early psychosis programs, adjusting the OC CREW program based on lessons learned. These lessons learned will not only contribute to improved participant outcomes, program efficiency and cost-effectiveness, but also help facilitate local planning efforts in identifying best practices for early psychosis programs.

Furthermore, the standardization of program outcomes proposed in the LHCN parallels Orange County's current effort in standardizing metrics within its behavioral health programs. As the County works to standardize its programs at the local level, participating in this project will provide a unique opportunity to standardize and compare OC CREW outcomes to a statewide benchmark.

Description of the Local Community Planning Process

As noted in the collective proposal, in 2017 and 2018, stakeholder feedback was gathered through meetings with relevant county and program leaders, individuals with lived experience of psychosis and family members of those with lived experience. In Spring 2018, Orange County participated in discussions regarding the project proposal. As part of the on-going local community planning process, Orange County plans to facilitate focus groups with OC CREW participants and families to contribute additional stakeholder feedback to the existing information gathered in this proposal.
On June 18, 2018, Orange County Innovation staff presented the LHCN Project to the local MHSA Steering Committee and addressed questions related to the proposed implementation plan, goals, staffing and budget. The MHSA Steering Committee voted to move forward with pursuing the proposal as an Innovation project.

The project was posted for 30-day public comment on June 20, 2018 through July 20, 2018, and received no questions or comments related to the proposal. A public hearing was held on July 25, 2018, during which the Orange County Mental Health Board unanimously approved moving forward with this innovation proposal.

The Orange County Health Care Agency will seek approval from the Board of Supervisors to join the Collaborative Statewide Early Psychosis Learning Health Care Network Project in January 2019.

Budget Narrative and Grids

Total Budget Request by Fiscal Year:

Total budget by fiscal year for the county collaborative portion of the costs.

	FY 18/19	FY 19/20	FY 20/21	FY 21/22	FY 22/23	FY23/24	TOTAL
Total County Contribution to Collaborative	$249,912	$499,824	$499,824	$499,824	$499,824	$249,912	**$2,499,199**

Budget Narrative for LHCN and Evaluation:

A detailed budget narrative for the entire county collaborative is described above. Orange county is contributing 19% of the funds in the county collaborative for the LHCN and evaluation. This proportion is based off of county size of all participating LHCN counties.

Budget by Fiscal Year and Specific Budget Category for LHCN and Evaluation for Orange County:

BUDGET CONTEXT - EXPENDITURES BY FUNDING SOURCE AND FISCAL YEAR (FY)								
EXPENDITURES								
		1/1/19-6/30/19	**7/1/19-6/30/20**	**7/1/20-6/30/21**	**7/1/21-6/30/22**	**7/1/22-6/30/23**	**7/1/23-12/31/23**	**1/1/19-12/31/23**
PERSONNEL COSTS (salaries, wages, benefits)		**FY 18/19 (6 mo)**	**FY 19/20 (12 mo)**	**FY 20/21 (12 mo)**	**FY 21/22 (12 mo)**	**FY 22/23 (12 mo)**	**FY 23/24 (6 mo)**	**TOTAL**
1.	Salaries	$8,809	$27,697	$30,932	$30,362	$30,700	$16,605	$145,105
2.	Benefits	$3,233	$10,743	$12,388	$12,487	$13,272	$7,403	$59,528
3.	Indirect Costs	$2,125	$6,784	$7,645	$7,562	$7,760	$4,237	$36,112
4.	Total Personnel Costs	$14,168	$45,224	$50,965	$50,411	$51,732	$28,245	$240,745
OPERATING COSTS		**FY 18/19 (6 mo)**	**FY 19/20 (12 mo)**	**FY 20/21 (12 mo)**	**FY 21/22 (12 mo)**	**FY 22/23 (12 mo)**	**FY 23/24 (6 mo)**	**TOTAL**
5.	Direct Costs							
6.	Indirect Costs							
7.	Total Operating Costs							
NONRECURRING COSTS (equipment, technology)		**FY 18/19 (6 mo)**	**FY 19/20 (12 mo)**	**FY 20/21 (12 mo)**	**FY 21/22 (12 mo)**	**FY 22/23 (12 mo)**	**FY 23/24 (6 mo)**	**TOTAL**
8a.	Direct Costs (Supplies)	$4,203	$2,227	$2,036	$1,486	$1,486	$743	$12,182
8b.	Direct Costs (Travel)	$239	$1,768	$2,198	$2,055	$1,386	$1,481	$9,128

8c.	Direct Costs (Other)	$48	$287	$48	$287	$48	$48	$765
9.	Indirect Costs	$792.33	$755.65	$755.65	$675.53	$515.29	$401.02	$3,895
10.	Total Operating Costs	$5,282	$5,038	$5,038	$4,504	$3,435	$2,673	$25,970
CONSULTANT COSTS/ CONTRACTS (clinical training, facilitator, evaluation)		**FY 18/19 (6 mo)**	**FY 19/20 (12 mo)**	**FY 20/21 (12 mo)**	**FY 21/22 (12 mo)**	**FY 22/23 (12 mo)**	**FY 23/24 (6 mo)**	**TOTAL**
11a.	Direct Costs (Subawards)	$46,453	$89,430	$93,916	$95,206	$98,956	$49,582	$473,545
11b.	Direct Costs (Consultant)	$64,758	$50,292	$18,381	$15,114	$6,051	$2,939	$157,536
12.	Indirect Costs	$11,427.91	$8,875.07	$3,243.76	$2,667.12	$1,067.90	$518.66	$27,800
13.	Total Consultant Costs	$122,639	$148,597	$115,541	$112,987	$106,076	$53,040	$658,881
OTHER EXPENDITURES (please explain in budget narrative)		**FY 18/19 (6 mo)**	**FY 19/20 (12 mo)**	**FY 20/21 (12 mo)**	**FY 21/22 (12 mo)**	**FY 22/23 (12 mo)**	**FY 23/24 (6 mo)**	**TOTAL**
14.								
15.								
16.	Total Other Expenditures							
BUDGET TOTALS:								
Personnel (salaries and benefits)		$12,043	$38,440	$43,320	$42,849	$43,973	$24,008	$204,633
Direct Costs (consultation, nonrecurring costs)		$115,701	$144,004	$116,580	$114,148	$107,928	$54,794	$653,155
Indirect Costs (15% TC)		$14,345	$16,414	$11,644	$10,904	$9,343	$5,156	$67,808
TOTAL INNOVATION BUDGET		**$142,089**	**$198,859**	**$171,544**	**$167,902**	**$161,243**	**$83,959**	**$925,595**

Budget Narrative for County Specific Needs:

Personnel

The personnel for Orange County will include in-kind staff within the Innovation and OC CREW programs, as well as one part-time program manager that will be hired through California Mental Health Services Authority (CalMHSA) for the oversight and management of this project. The total estimated 5-year budget for personnel, including benefits, is $1,207,643.

Personnel will include:

- *Research Analyst* who will assist with data collection and participate in LHCN meetings throughout the duration of the project
- *Office Support* who will assist the research analyst with entry, as needed
- *Innovation Project Manager* who will participate in LHCN meetings, provide project updates to stakeholders and prepare project reports, as needed

- *OC CREW Program Manager* who oversees the OC CREW program and will participate in meetings with OC CREW staff, LHCN evaluators and other counties participating in the LHCN project
- *Clinicians* who will be responsible for participating in LHCN feedback groups as needed and administering tablets to participants during the identified data collection period
- *Psychiatrist* who will participate in feedback groups and administer tablets to participants as needed
- *Behavioral Health Nurse* who will participate in feedback groups and administer tablets to participants as needed
- *Mental Health Specialists* who will participate in feedback groups and administer tablets to participants as needed
- *LHCN Project Manager* who will be hired through CalMHSA. The Project Manager will collaborate with the Innovation and OC CREW managers for the duration of this project and will be primarily responsible for the administrative oversight, coordination, and planning for this project.

Operating Costs

The total estimated indirect cost for this 5-year project is $221,876.

Other Costs

- *Travel*: This portion of the budget accounts for costs associated with project staff attending LHCN meetings; presentations or updates to the MHSOAC upon request. The total estimated cost for travel for this 5-year project is $25,000.
- *CalMHSA*: Orange County will utilize a Joint Powers of Authority with CalMHSA, which will act as the fiscal intermediary and contracting agent for this project. As such, 5% of the total budget will be allocated to CalMHSA, for a 5-year total estimated cost of $119,006.

Total Estimated Budget

Orange County's total estimated 5-year budget, including the evaluation, is $2,499,119. A detailed breakdown of the budget by fiscal year is provided in the grid below.

Budget by Fiscal Year and Specific Budget Category for County Specific Needs

	BUDGET BY FISCAL YEAR AND SPECIFIC BUDGET CATEGORY FOR COUNTY SPECIFIC NEEDS							
	EXPENDITURES							
PERSONNEL COSTS (salaries, wages, benefits)		**FY 18/19 (6 mo)**	**FY 19/20 (12 mo)**	**FY 20/21 (12 mo)**	**FY 21/22 (12 mo)**	**FY 22/23 (12 mo)**	**FY 23/24 (6 mo)**	**TOTAL**
1.	Salaries	$120,764	$241,529	$241,529	$241,529	$241,529	$120,674	$1,207,643
2.	Direct Costs							
3.	Indirect Costs							
4.	Total Personnel Costs	**$120,764**	**$241,529**	**$241,529**	**$241,529**	**$241,529**	**$120,764**	**$1,207,643**
OPERATING COSTS		**FY 18/19 (6 mo)**	**FY 19/20 (12 mo)**	**FY 20/21 (12 mo)**	**FY 21/22 (12 mo)**	**FY 22/23 (12 mo)**	**FY 23/24 (6 mo)**	**TOTAL**
5.	Direct Costs							
6.	Indirect Costs	$22,188	$44,375	$44,375	$44,375	$44,375	$22,188	$221,876
7.	Total Operating Costs	**$22,188**	**$44,375**	**$44,375**	**$44,375**	**$44,375**	**$22,188**	**$221,876**

NONRECURRING COSTS (equipment, technology)		FY 18/19 (6 mo)	FY 19/20 (12 mo)	FY 20/21 (12 mo)	FY 21/22 (12 mo)	FY 22/23 (12 mo)	FY 23/24 (6 mo)	TOTAL
8								
9.								
10.	Total Non-recurring Costs							
CONSULTANT COSTS/ CONTRACTS (clinical training, facilitator, evaluation)		**FY 18/19 (6 mo)**	**FY 19/20 (12 mo)**	**FY 20/21 (12 mo)**	**FY 21/22 (12 mo)**	**FY 22/23 (12 mo)**	**FY 23/24 (6 mo)**	**TOTAL**
11a.	Salaries							
11b.	Direct Costs							
12.	Indirect Costs							
13.	Total Consultant Costs							
OTHER EXPENDITURES (please explain in budget narrative)		**FY 18/19 (6 mo)**	**FY 19/20 (12 mo)**	**FY 20/21 (12 mo)**	**FY 21/22 (12 mo)**	**FY 22/23 (12 mo)**	**FY 23/24 (6 mo)**	**TOTAL**
14.	Travel	$2,500	$5,000	$5,000	$5,000	$5,000	$2,500	$25,000
15.	CalMHSA	$11,901	$23,801	$23,801	$23,801	$23,801	$11,901	$119,006
16.	Total Other Expenditures	**$14,401**	**$28,801**	**$28,801**	**$28,801**	**$28,801**	**$14,401**	**$144,006**
	BUDGET TOTALS:							
Personnel (line 1)		$120,764	$241,529	$241,529	$241,529	$241,529	$120,764	$1,207,643
Direct Costs (add lines 2, 5 and 11 from above)								
Indirect Costs (add lines 3, 6 and 12 from above)		$22,188	$44,375	$44,375	$44,375	$44,375	$22,188	$221,876
Non-Recurring costs (line 10)								
Consultant costs/ contracts (clinical direct service contract) (line 13)								
Other expenditures (line 16)		$14,401	$28,801	$28,801	$28,801	$28,801	$14,401	$144,006
TOTAL INNOVATION BUDGET		**$157,353**	**$314,705**	**$314,705**	**$314,705**	**$314,705**	**$157,353**	**$1,573,525**

Total Budget Context – Expenditures by Funding Source and Fiscal Year (FY):

	TOTAL BUDGET CONTEXT- EXPENDITURES BY FUNDING SOURCE AND FISCAL YEAR (FY)							
	ADMINISTRATION:							
A.	**Estimated total mental health expenditures for ADMINISTRATION for the entire duration of this INN Project by FY & the following funding sources:**	**FY 18/19 (6 mo)**	**FY 19/20 (12 mo)**	**FY 20/21 (12 mo)**	**FY 21/22 (12 mo)**	**FY 22/23 (12 mo)**	**FY 23/24 (6 mo)**	**TOTAL**
1.	Innovative MHSA Funds	$157,353	$314,705	$314,705	$314,705	$314,705	$157,353	**$1,573,525**

2.	Federal Financial Participation							
3.	1991 Realignment							
4.	Behavioral Health Subaccount							
5.	Other Funding							
6.	**Total Proposed Administration**	$157,353	$314,705	$314,705	$314,705	$314,705	$157,353	**$1,573,525**
	EVALUATION:							
B.	**Estimated total mental health expenditures for EVALUATION for the entire duration of this INN Project by FY & the following funding sources:**	**FY 18/19 (6 mo)**	**FY 19/20 (12 mo)**	**FY 20/21 (12 mo)**	**FY 21/22 (12 mo)**	**FY 22/23 (12 mo)**	**FY 23/24 (6 mo)**	**TOTAL**
1.	Innovative MHSA Funds	$142,089	$198,859	$171,544	$167,902	$161,243	$83,959	$925,595
2.	Federal Financial Participation							
3.	1991 Realignment							
4.	Behavioral Health Subaccount							
5.	Other Funding							
6.	**Total Proposed Evaluation**	**$142,089**	**$198,859**	**$171,544**	**$167,902**	**$161,243**	**$83,959**	**$925,595**
	TOTAL:							
C.	**Estimated TOTAL mental health expenditures (this sum to total for funding requested) for the entire duration of this INN Project by FY & the following funding sources:**	**FY 18/19 (6 mo)**	**FY 19/20 (12 mo)**	**FY 20/21 (12 mo)**	**FY 21/22 (12 mo)**	**FY 22/23 (12 mo)**	**FY 23/24 (6 mo)**	**TOTAL**
1.	Innovative MHSA Funds	$249,912	$499,824	$499,824	$499,824	$499,824	$249,912	$2,499,119
2.	Federal Financial Participation							
3.	1991 Realignment							
4.	Behavioral Health Subaccount							
5.	Other Funding							
6.	**Total Proposed Expenditures**	**$249,912**	**$499,824**	**$499,824**	**$499,824**	**$499,824**	**$249,912**	**$2,499,119**

Appendix III: San Diego County

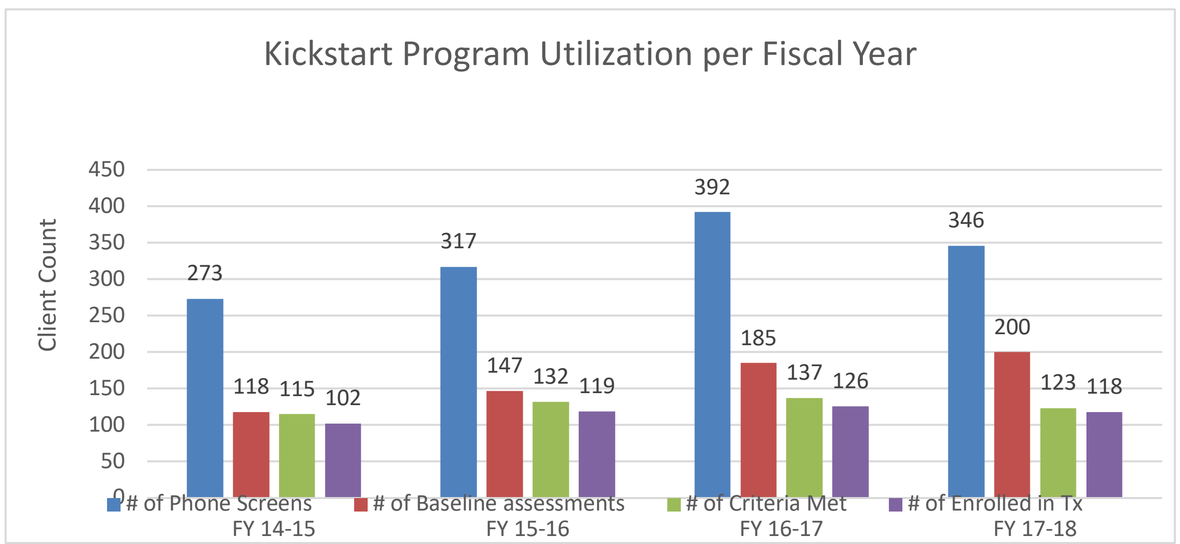
County Contact and Specific Dates

- Primary County Contact (Name, Email, Phone): Cecily Thornton-Stearns
- Date Proposal posted for 30-day Public Review: 9/11/2018
- Date of Local MH Board hearing: 11/1/2018
- Date of BOS approval or calendared date to appear before BOS: 11/13/2018

Description of the Local Need

Each year, Behavioral Health Services gathers the community for a series of community engagement forums. As a collective voice for San Diego County, participants express their needs and concerns about services. The forums are carefully designed to include members of un-served and underserved communities. The results are published in annual reports that are reviewed publicly and shared with local and state authorities.

A recurring theme during community engagement forums is the need for earlier assessment and intervention. In FY 2015, participants identified school-based early intervention as a priority, including teacher training and after-school services. In FY 2016, participants emphasized the need for community education of signs and symptoms and prevention strategies in homes and schools. In 2017, participants identified stigma about seeking help or lack of knowledge of services as the most likely barriers. A relevant priority included system simplification to ensure an effective 'no wrong door' approach.
More than 2,000 stakeholders participated in the forums cited in the information above.
Within our Early Episode Psychosis provider, Pathways Community Services-The Kickstart Program, there has been a steady utilization of services including screening, assessment and for many youth/young adults specialized targeted services:



Description of the Response to the Local Need

The Prevention and Early Intervention (PEI) component of the Mental Health Services Act (MHSA), coupled with a legislative focus on early psychosis (AB 1315, SB 1004), has served as a catalyst for the delivery of early psychosis (EP) services across California. The Kickstart program serves individuals early in the course of severe mental illness, with a goal of preventing mental disorders from becoming severe and disabling.

This proposed project would address needs identified in our community through our stakeholder process by making a change to the existing practice by introducing a collaborative learning health care network to support quality improvements, consumer engagement and provider use of measurement-based care in our EP program.

This project, led by UC Davis, Behavioral Health Center of Excellence in partnership with other universities and multiple California counties, will give clinicians the opportunity to share and discuss outcome measure results with clients immediately after they are completed, allow programs to learn from each other through a training and technical assistance collaborative, and position the state to participate in the development of a national network to inform and improve care for individuals with early psychosis across the US.

Cultural & Linguistic Competency
San Diego County is home to more than 3.3 million Californians, of which more than 700,000 are Medi-Cal beneficiaries. The County of San Diego Health and Human Services Agency, Behavioral Health Services (BHS), provides behavioral health services and programs to more than 70,000 individuals each year. As an international port city, San Diego is home to many communities of immigrants and refugees. Threshold languages include Spanish, Tagalog, Arabic, Vietnamese, and Farsi.

The 2017 BHS Community Engagement report defines high value care as services that allow San Diegans to feel comfortable reaching out for help, and to connect with someone who understands their community, culture, language, and lived experiences.

In addition to regular outreach, public forums and focus groups, BHS maintains a regular working group to address cultural and linguistic needs. The Cultural Competency Resource Team (CCRT) supports the strategic Cultural Competence Plan. Members are appointed by the Deputy Directors of BHS, representing units and disciplines within BHS, as well as members-at-large, including consumers and family representatives. Key participants include BHS Quality Improvement (QI), the Mental Health Contractors Association, and behavioral health providers. The BHS/State Ethnic Services Coordinator, currently the Deputy Director of the BHS Adult and Older Adult System of Care, acts as primary staff support.

Successful approaches utilized in San Diego include the following:
BHS has successfully used cultural broker models in a number of different programs, an approach which we can continue to develop with input from our stakeholders through CCRT, Community Engagement Forums, and councils. Whether referred to as promotores, community health workers, or community advocates, the approach receives strong support from stakeholders across the system of care.

Successful approaches utilized by the Kickstart include the following:
Kickstart staff have attended LGBTQIP+ trainings which have been helpful in communication with the youth of this culture. Sensitivity and focus upon correct usage of pronouns, and acknowledging the unique adversity and marginalization of this community has allowed us to make meaningful connections with these clients. LGBTQIP+ represent 22% of the program population.

These approaches have also been successful in Kickstart's monthly LGBTQIP+ process groups, which have been well attended and reportedly beneficial. The program has focused on outreach to largely Hispanic communities such as Chula Vista and City Heights, and has reached out to Native American Indian communities through presentations to the Southern Indian Health Council and the Native American Health Center. This has translated into an increase of diversity of program participants who are represented by 53% of clients who identify as Hispanic, 36% identify as African American, 11%

identify as Asian/Pacific Islander, 24% identify as Caucasian, and 1% identify as Native American.

The program has also presented to faith based communities through Mental Health Ministries and the San Diego Diocese, increasing referrals from San Diego's religious and spiritual populations. Through regular contact with religious participants and their families, the staff have developed a remarkable understanding and sensitivity to spiritual explanations for mental health symptoms. Staff have been able to help expand these families' perspectives to include psychological and psychiatric viewpoints, opening them to effective treatment.

Description of the Local Community Planning Process

The Community Program Planning (CPP) process provides a structured way for San Diego County, in partnership with stakeholders, to collaborate and determine where to focus resources and effectively utilize MHSA funds in order to meet the needs of County residents. The CPP process includes participation from the San Diego County Behavioral Health Advisory Board, System of Care Councils, stakeholders, organizations, and individuals. Throughout the year, BHS stakeholder-led councils also provide a forum for council representatives and the community to stay informed and provide input. The CPP process is ongoing and the County encourages open dialogue to provide all community members with the opportunity to provide input of future planning.

This proposal for utilization of INN funding for this project was posted for 30 day comment and comments will be utilized to guide this endeavor.

Total Budget Request by Fiscal Years:

Total budget by fiscal year for the county collaborative portion of the costs.

	FY 18/19	FY 19/20	FY 20/21	FY 21/22	FY 22/23	FY 23/24	TOTAL
Total County Contribution to Collaborative	$157,576	$227,148	$219,927	$216,285	$209,626	$96,828	**$1,127,389**

Budget Narrative for LHCN and Evaluation:

Nearing the conclusion of this program, if the program outcomes are successful, the services are in alignment with County and community priorities, and subject to the availability of funding, the County will evaluate at that time to determine the sustainability of the program.

A detailed budget narrative for the entire county collaborative is described above. San Diego county is contributing 19% of the funds in the county collaborative for the LHCN and evaluation. This proportion is based off of county size of all participating LHCN counties.

Budget by Fiscal Year and Specific Budget Category for LHCN and Evaluation for San Diego County:

BUDGET CONTEXT - EXPENDITURES BY FUNDING SOURCE AND FISCAL YEAR (FY)								
EXPENDITURES								
		1/1/19-6/30/19	**7/1/19-6/30/20**	**7/1/20-6/30/21**	**7/1/21-6/30/22**	**7/1/22-6/30/23**	**7/1/23-12/31/23**	**1/1/19-12/31/23**
PERSONNEL COSTS (salaries, wages, benefits)		**FY 18/19 (6 mo)**	**FY 19/20 (12 mo)**	**FY 20/21 (12 mo)**	**FY 21/22 (12 mo)**	**FY 22/23 (12 mo)**	**FY 23/24 (6 mo)**	**TOTAL**
1.	Salaries	$8,809	$27,697	$30,932	$30,362	$30,700	$16,605	$145,105
2.	Benefits	$3,233	$10,743	$12,388	$12,487	$13,272	$7,403	$59,528

3.	Indirect Costs	$2,125	$6,784	$7,645	$7,562	$7,760	$4,237	$36,112
4.	Total Personnel Costs	$14,168	$45,224	$50,965	$50,411	$51,732	$28,245	$240,745
OPERATING COSTS		**FY 18/19 (6 mo)**	**FY 19/20 (12 mo)**	**FY 20/21 (12 mo)**	**FY 21/22 (12 mo)**	**FY 22/23 (12 mo)**	**FY 23/24 (6 mo)**	**TOTAL**
5.	Direct Costs							
6.	Indirect Costs							
7.	Total Operating Costs							
NONRECURRING COSTS (equipment, technology)		**FY 18/19 (6 mo)**	**FY 19/20 (12 mo)**	**FY 20/21 (12 mo)**	**FY 21/22 (12 mo)**	**FY 22/23 (12 mo)**	**FY 23/24 (6 mo)**	**TOTAL**
8a.	Direct Costs (Supplies)	$4,203	$2,227	$2,036	$1,486	$1,486	$743	$12,182
8b.	Direct Costs (Travel)	$239	$1,768	$2,198	$2,055	$1,386	$1,481	$9,128
8c.	Direct Costs (Other)	$48	$287	$48	$287	$48	$48	$765
9.	Indirect Costs	$792.33	$755.65	$755.65	$675.53	$515.29	$401.02	$3,895
10.	Total Operating Costs	$5,282	$5,038	$5,038	$4,504	$3,435	$2,673	$25,970
CONSULTANT COSTS/ CONTRACTS (clinical training, facilitator, evaluation)		**FY 18/19 (6 mo)**	**FY 19/20 (12 mo)**	**FY 20/21 (12 mo)**	**FY 21/22 (12 mo)**	**FY 22/23 (12 mo)**	**FY 23/24 (6 mo)**	**TOTAL**
11a.	Direct Costs (Subawards)	$46,453	$89,430	$93,916	$95,206	$98,956	$48,290	$472,253
11b.	Direct Costs (Consultant)	$65,885	$50,263	$18,381	$15,114	$6,051	$2,939	$158,634
12.	Indirect Costs	$11,626.74	$8,870.01	$3,243.76	$2,667.12	$1,067.90	$518.66	$27,994
13.	Total Consultant Costs	$123,965	$148,563	$115,541	$112,987	$106,076	$51,748	$658,881
OTHER EXPENDITURES (please explain in budget narrative)		**FY 18/19 (6 mo)**	**FY 19/20 (12 mo)**	**FY 20/21 (12 mo)**	**FY 21/22 (12 mo)**	**FY 22/23 (12 mo)**	**FY 23/24 (6 mo)**	**TOTAL**
14.								
15.								
16.	Total Other Expenditures							
BUDGET TOTALS:								
Personnel (salaries and benefits)		$12,043	$38,440	$43,320	$42,849	$43,973	$24,008	$204,633
Direct Costs (consultation, nonrecurring costs)		$116,828	$143,975	$116,580	$114,148	$107,928	$53,502	$652,961
Indirect Costs (15% TC)		$14,544	$16,409	$11,644	$10,904	$9,343	$5,156	$68,001

TOTAL INNOVATION BUDGET	$143,415	$198,825	$171,544	$167,902	$161,243	$82,667	$925,595

Budget Narrative for County Specific Needs:

EP Program Manager/Administrator

** 1 per program/site/team**

The program manager will attend monthly project meetings and quarterly learning health care network meetings. They will also meet weekly with program support staff to ensure task completion to meet project goals. They will oversee the fidelity evaluation at their site.

Years 1-5: .05 FTE (Average 2 hrs per week)

EP Program Support Person (e.g. clinic coordinator):

** 1 per program/site/team**

The program support person will participate in monthly project meetings and weekly meetings with program manager. They will schedule meetings associated with qualitative data collection at their site, including meetings with client/family, program, and county stakeholders. They will provide administrative support for the fidelity evaluation at their site, including scheduling of site meetings and health record abstraction (est. 1 hr per chart for 10 charts). They will the administer tablets to clients 3 times per year, roughly one assessment per day accounting for a 25% no show rate, for every 50 clients.

Year 1: .10 FTE (Average 4 hrs per week)

Years 2 - Year 5 .25 FTE (Average 2 hrs/day per week)

Budget by Fiscal Year and Specific Budget Category for County Specific Needs:

	BUDGET BY FISCAL YEAR AND SPECIFIC BUDGET CATEGORY FOR COUNTY SPECIFIC NEEDS							
	EXPENDITURES							
PERSONNEL COSTS (salaries, wages, benefits)		FY 18/19 (6 mo)	FY 19/20 (12 mo)	FY 20/21 (12 mo)	FY 21/22 (12 mo)	FY 22/23 (12 mo)	FY 23/24 (6 mo)	TOTAL
1.	Salaries							
2.	Direct Costs							
3.	Indirect Costs							
4.	Total Personnel Costs							
OPERATING COSTS		FY 18/19 (6 mo)	FY 19/20 (12 mo)	FY 20/21 (12 mo)	FY 21/22 (12 mo)	FY 22/23 (12 mo)	FY 23/24 (6 mo)	TOTAL
5.	Direct Costs							
6.	Indirect Costs							
7.	Total Operating Costs							
NONRECURRING COSTS (equipment, technology)		FY 18/19 (6 mo)	FY 19/20 (12 mo)	FY 20/21 (12 mo)	FY 21/22 (12 mo)	FY 22/23 (12 mo)	FY 23/24 (6 mo)	TOTAL
8								

9.								
10.	Total Non-recurring Costs							
CONSULTANT COSTS/ CONTRACTS (clinical training, facilitator, evaluation)		**FY 18/19 (6 mo)**	**FY 19/20 (12 mo)**	**FY 20/21 (12 mo)**	**FY 21/22 (12 mo)**	**FY 22/23 (12 mo)**	**FY 23/24 (6 mo)**	**TOTAL**
11a.	Salaries	$9,766	$19,533	$33,368	$33,368	$33,368	$9,766	**$139,168**
11b.	Direct Costs	$2,930	$5,860	$10,010	$10,010	$10,010	$2,930	**$41,751**
12.	Indirect Costs	$1,465	$2,930	$5,005	$5,005	$5,005	$1,465	**$20,875**
13.	Total Consultant Costs	$14,161	$28,323	$48,383	$48,383	$48,383	$14,161	**$201,794**
OTHER EXPENDITURES (please explain in budget narrative)		**FY 18/19 (6 mo)**	**FY 19/20 (12 mo)**	**FY 20/21 (12 mo)**	**FY 21/22 (12 mo)**	**FY 22/23 (12 mo)**	**FY 23/24 (6 mo)**	**TOTAL**
14.								
15.								
16.	Total Other Expenditures							
	BUDGET TOTALS:							
Personnel (line 1)								
Direct Costs (add lines 2, 5 and 11 from above)								
Indirect Costs (add lines 3, 6 and 12 from above)								
Non-Recurring costs (line 10)								
Consultant costs/ contracts (clinical direct service contract) (line 13)		$14,161	$28,323	$48,383	$48,383	$48,383	$14,161	**$201,794**
Other expenditures (line 16)								
TOTAL INNOVATION BUDGET		$14,161	$28,323	$48,383	$48,383	$48,383	$14,161	**$201,794**

Budget Narrative for Total Budget Context- Expenditures by Funding Source and Fiscal Year: All funds for the county collaborative are planned to come from Innovative MHSA funds.

Total Budget Context- Expenditures by Funding Source and Fiscal Year (FY):

	TOTAL BUDGET CONTEXT- EXPENDITURES BY FUNDING SOURCE AND FISCAL YEAR (FY)							
	ADMINISTRATION:							
A.	**Estimated total mental health expenditures for ADMINISTRATION for the entire duration of this INN Project by FY & the following funding sources:**	**FY 18/19 (6 mo)**	**FY 19/20 (12 mo)**	**FY 20/21 (12 mo)**	**FY 21/22 (12 mo)**	**FY 22/23 (12 mo)**	**FY 23/24 (6 mo)**	**TOTAL**

1.	Innovative MHSA Funds	$14,161	$28,323	$48,383	$48,383	$48,383	$14,161	**$201,794**
2.	Federal Financial Participation							
3.	1991 Realignment							
4.	Behavioral Health Subaccount							
5.	Other Funding							
6.	**Total Proposed Administration**	$14,161	$28,323	$48,383	$48,383	$48,383	$14,161	**$201,794**
	EVALUATION:							
B.	**Estimated total mental health expenditures for EVALUATION for the entire duration of this INN Project by FY & the following funding sources:**	**FY 18/19 (6 mo)**	**FY 19/20 (12 mo)**	**FY 20/21 (12 mo)**	**FY 21/22 (12 mo)**	**FY 22/23 (12 mo)**	**FY 23/24 (6 mo)**	**TOTAL**
1.	Innovative MHSA Funds	$143,415	$198,825	$171,544	$167,902	$161,243	$82,667	**$925,595**
2.	Federal Financial Participation							
3.	1991 Realignment							
4.	Behavioral Health Subaccount							
5.	Other Funding							
6.	**Total Proposed Evaluation**							
	TOTAL:							
C.	**Estimated TOTAL mental health expenditures (this sum to total for funding requested) for the entire duration of this INN Project by FY & the following funding sources:**	**FY 18/19 (6 mo)**	**FY 19/20 (12 mo)**	**FY 20/21 (12 mo)**	**FY 21/22 (12 mo)**	**FY 22/23 (12 mo)**	**FY 23/24 (6 mo)**	**TOTAL**
1.	Innovative MHSA Funds	$157,576	$227,148	$219,927	$216,285	$209,626	$96,828	**$1,127,389**
2.	Federal Financial Participation							
3.	1991 Realignment							
4.	Behavioral Health Subaccount							
5.	Other Funding							
6.	**Total Proposed Expenditures**	**$157,576**	**$227,148**	**$219,927**	**$216,285**	**$209,626**	**$96,828**	**$1,127,389**

Appendix IV: Solano County

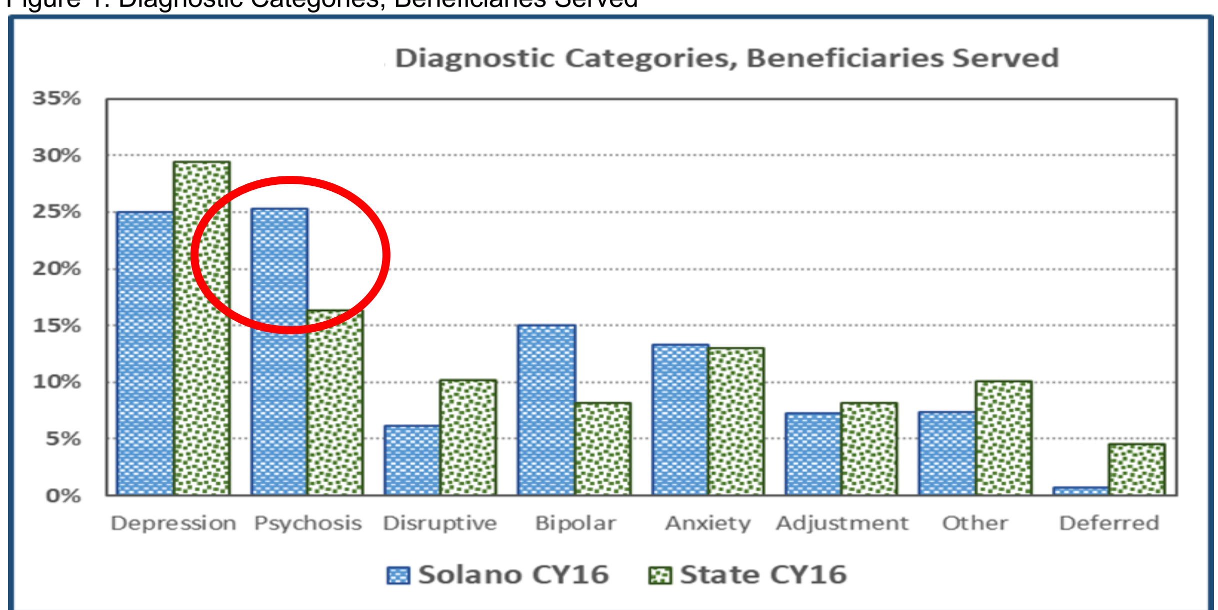
County Contact and Specific Dates

- Primary County Contact (Name, Email, Phone): Tracy Lacey, tclacey@solanocounty.com, 707-784-8213
- Date Proposal posted for 30-day Public Review: June 28, 2018 through July 27, 2018.
- Date of Local MH Board hearing: August 21, 2018
- Date of BOS approval or calendared date to appear before BOS: September 11, 2018

Description of the Local Need

During the most recent External Quality Review Organization (EQRO) site visit in January 2018 the ERRO team provided routine data regarding the Mental Health Plan (MHP). One such data point was related to diagnostic categories for beneficiaries served, which shows that compared to other County MHPs statewide, Solano County shows a higher proportion of individuals with psychotic disorders in the population served.

Figure 1: Diagnostic Categories, Beneficiaries Served



Source: EQRO Report 2017-Annual Medi-cal Claims Data

While Solano County Behavioral Health (SCBH) believes that this finding may be in part related to consumers with dual diagnosis whereby behaviors related to substance use may mimic symptoms of psychosis, the findings are significant and warrant further exploration. The fact that the rate of psychosis is higher in our community, the need for more proactive efforts toward early intervention in psychotic illnesses is imperative. SCBH does fund an Early Psychosis (EP) program using MHSA PEI and Substance Abuse and Mental Health Services Administration (SAMHSA) Mental Health Block Grant (MHBG) funds. Over the course of the last several fiscal years (FY) the County and EP service provider have noted a significant shift in the ages of consumers diagnosed with their first psychotic episode, whereby there is a trend of youth being diagnosed with their first psychotic episode at younger ages. Approximately half of all consumers served through the EP program each year are between the ages of 12-17 years old. This trend is alarming and is further cause to strengthen services related to the early identification and treatment of individuals with psychosis with a goal of preventing mental disorders from becoming severe and disabling.

Over the last several years SCBH has engaged in several comprehensive community stakeholder planning processes, including the development of the current MHSA Three-Year Integrated Plan 2017/20, Annual Update FY2017/18, and community planning related to the development of the *Solano County Suicide Prevention Strategic Plan.* Consistently stakeholders have highlighted the following priorities and/or needs: improve the overall support for consumers with serious mental illness (SMI), particularly adults; expansion of crisis services specifically mobile crisis to reduce the need for crisis stabilization and/or hospitalization; reduce suicides; address homelessness for the SMI population, and to continue to provide prevention and early intervention services to children and youth in order to prevent the development of disabling mental health conditions. The current EP direct service program continues to be supported and is perceived as a necessary program in the continuum of care.

In reviewing data related to inpatient admissions for children/youth for the last two full fiscal years, FY2016/17 and FY2017/18, it should be noted that there was a 43% increase in the number of admissions for children/youth. Additionally, there was a 42% increase in the number of children/youth consumers who were discharged from an inpatient facilitated who were re-admitted to an inpatient facility within 30 days of discharge.

Figure 2: Child/Youth Hospitalizations

Fiscal Year	Total # of Child Inpatient Hosp.	Total # of Child Discharges	Total # of Child Rehospitalizations within 30 days of discharge & % of total of discharges	
2016/17	74	76	12	15.79%
2017/18	106	99	17	17.17%

Source: Solano County Avatar Electronic Health Record

In reviewing data related to inpatient admissions for adults for the last two full fiscal years, FY2016/17 and FY2017/18, it should be noted that there was a 29.5% increase in the number of admissions for adults. Additionally, there was a 16% increase in the number of adult consumers who were discharged from an inpatient facilitated who were re-admitted to an inpatient facility within 30 days of discharge.

Figure 3: Adult Hospitalizations

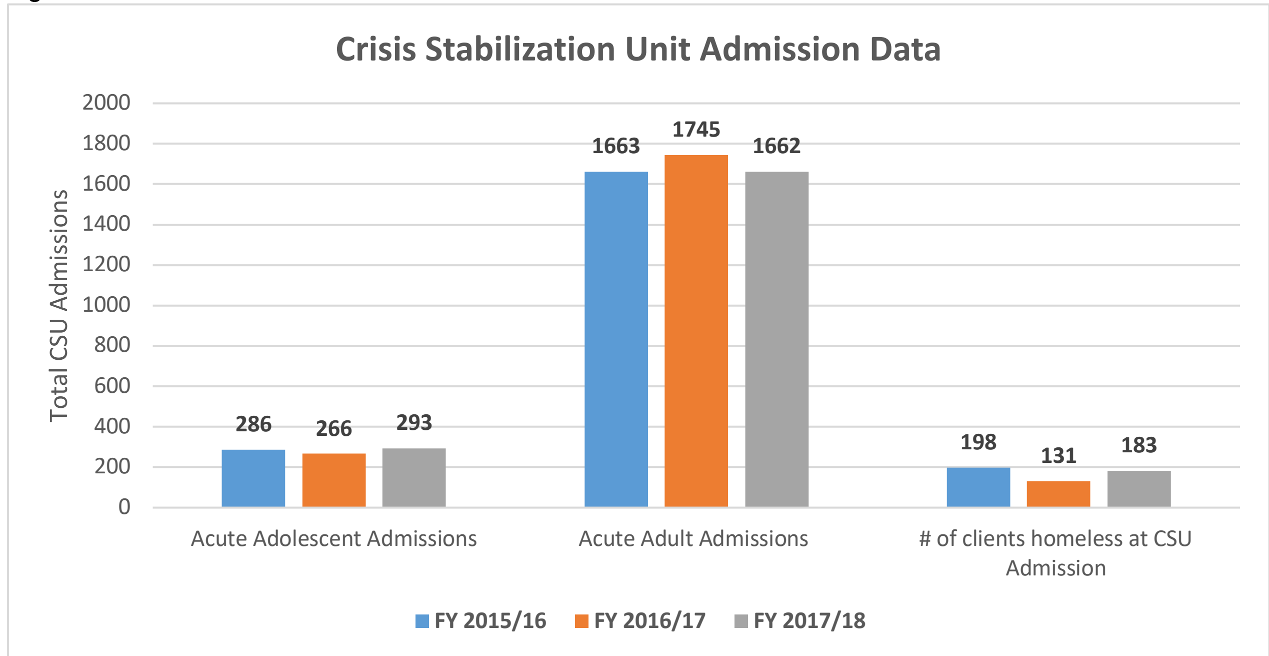
Fiscal Year	Total # of Adult Inpatient Hosp.	Total # of Adult Discharges	Total # of Adult Rehospitalizations within 30 days of discharge & % of total of discharges	
2016/17	491	490	61	12.45%
2017/18	636	596	71	11.91%

Source: Solano County Avatar Electronic Health Record

Given the rate of psychosis is higher in Solano County, the usage of inpatient hospitalization and crisis stabilization services are leveraged to support consumers in crisis. The current local EP provider has been successful in regards to providing treatment and support for consumers served minimizing the need for inpatient hospital stays. In FY 2016/17 none (0%) of the consumers served had psychiatric hospitalizations for greater than 7 days and in FY 2017/18, only 5% (2) of the clients served had a psychiatric hospitalization for greater than 7 days.

A review of data related to Crisis Stabilization Unit (CSU) utilization for the last three full fiscal years indicated that there was a 10% increase in the number of admissions for adolescents. Additionally, there was a 40% increase in the number of consumers admitted to the CSU who were homeless at the time of admission. In FY16/17, 7.5% of adults admitted were homeless and in FY17/18 the number of adults who were homeless at admission increased to 11% of adults served at the CSU.

Figure 4: Crisis Stabilization Unit Utilization



Source: Monthly Reporting from CSU Provider

Like most California Counties, Solano County is struggling to adequately address the issue of homelessness in our community and have seen an increase in the number of homeless individuals over the last several years. According to the most recent Homeless Point-in-Time (PIT) Count, the population counted in Solano County who met the HUD definition of homelessness in a single 24-hour period in January 2017 was 1232, a 14% increase from 1082 in 2015. Of the 434 individuals who reported being chronically homeless, nearly half (48%) reported psychiatric or emotional conditions(*Housing First Solano. Housing Inventory County (HIC)and Homeless Point-in-Time Count (PIT).* 2018).

Given the SCBH data related to rate of diagnoses of psychosis and the decrease in age of first episode of psychosis, the 2017 Solano County PIT Count data associated to homelessness for transition-age youth whereby 192 youth were homeless with 16% of the youth considered sheltered while 84% of the youth were unsheltered further supports the need for effective early intervention programs.

Figure 5: Sub-Population Homeless Transition-Age Youth

Source: 2017 Solano County PIT Count

SCBH's goal is to be better able to identify consumers at risk of psychosis and to treat those who have had their first episode of psychosis more effectively to ensure that consumers can live healthy

and productive lives. The current EP provider has made positive impacts on consumers served, and by participating in the EP LHCN SCBH expects that we can further improve outcomes for consumers and reduce costs for crisis and inpatient services locally.

Description of the Response to the Local Need

By participating in the EP learning health care network (LHCN) using a software application (app) to collect consumer-and program-level metrics, SCBH will be better poised to evaluate the effectiveness of our local EP program in comparison to other local outpatient programs, as well other EP programs statewide. Additionally, the goals of the proposed LHCN project are aligned with several of the local identified needs: to improve overall support for consumers with serious mental illness (SMI); reduce the use of crisis stabilization services and/or hospitalization; and to continue to provide prevention and early intervention services to prevent the development of disabling mental health conditions. Providing appropriate early intervention with consumers with psychosis can ultimately result in reduced costs, homelessness for the SMI population, and suicide deaths. It is anticipated that by participating in this project the County will be able to provide EP services that are consumer driven, recovery-orientated and cost-effective.

Cultural & Linguistic Competency

It is Solano County's mission to ensure that all our programs under the MHP provide culturally and linguistically appropriate services. Spanish is currently the only threshold language in Solano County, however Tagalog a prominent language in our community. The EP program currently employs a bilingual Spanish-speaking Clinical Coordinator, who conducts phone screenings in Spanish, schedules appointments, and is available for translation/interpretation services. Additionally, the program has a bilingual Mental Health Clinician trained in the EBP model. During FY2017/18 SCBH leveraged SAMHSA Mental Health Block Grant (MHBG), First Episode Psychosis (FEP) funds to support the translation of the EP program model treatment materials into Spanish which will enhance the program's ability to work directly with mono-lingual Spanish-speaking consumers and their family members.

SCBH has implemented several strategies to address and reduce health disparities including a comprehensive 5-year MHSA funded Innovations project called the Interdisciplinary Collaboration and Cultural Transformation Model (ICCTM). The County has partnered with the University of California, Davis – Center for Reducing Health Disparities (CRHD) to implement this project, which aims to increase culturally and linguistically appropriate services for County-specific unserved and underserved populations with low mental health service utilization rates: the Latino, Filipino, and LGBTQ communities. The project includes the creation of a region-specific curriculum based on the National Culturally and Linguistically Appropriate Services (CLAS) standards and the local community's perspective on culturally competent practices that should be integrated into the current local mental health system to increase access to targeted populations. During Phase I of the project UC Davis CRHD conducted a very comprehensive health assessment of our community and mental health system of care which included key informant interviews, focus groups, community forums, and organizational surveys to gather information regarding the needs of the three target communities. Focus groups and community forums were comprised of consumers, family members, providers, and community partners from the three target communities. Additionally, quantitative data from the County's electronic health record was used to develop a baseline regarding access and penetration rates for the three target communities.

Phase II of the project, which began in FY17/18, includes the facilitation of CLAS Training for three cohorts of up to 30 people each. The cohorts include partners from different sectors including county and community-based mental health, law enforcement, education, health services, child welfare, the legal system, businesses, consumers, family members and specific representation from the three

target communities. The cohorts receive more in-depth training on a specialized curriculum that incorporates the CLAS standards and the findings of the local health assessment. Each cohort is tasked with designing up to 6 quality improvement (QI) action plans to improve the mental health system of care's response and support of our diverse community. Following the training the cohorts receive up to 5 months of coaching from the UC Davis team and support from the County to further refine the QI action plans to ready them for implementation. Training for CLAS Cohorts 1 and 2 was completed during FY17/18 and during FY18/19 the third and final CLAS Cohort will be held. In addition to the coaching component, the QI action plans will begin to be implemented over the course of this FY. Phase III of the project involves the ongoing implementation of the QI action plans and evaluation.

In addition to the MHSA Innovations project, Solano County has several other initiatives that are addressing cultural competency and health care disparities. The Hispanic Outreach and Latino Access (HOLA) program consists of a licensed mental health clinician who conducts outreach with schools, health clinics, churches, local migrant camps, etc. for the purpose of engaging the Latino community in order to increase access and penetration rates. A similar outreach program, called KAAGAPAY "Reliable Companion" is focused on engaging the Filipino community to increase access and penetration rates for the Filipino community. MHSA prevention and early intervention (PEI) funds are used to support the LGBTQ Outreach and Access program that provides preventative social and support groups and early intervention brief counseling for members of the LGBTQ community. Additionally, PEI funds are used to support the African American Faith-Based Initiative (AAFBI) Mental Health Friendly Communities project, which includes training for faith-based leaders on the signs and symptoms of mental health, support for faith communities to build internal support systems to address mental health needs of congregants, and training for providers on how to engage consumers from the African American community.

Related to the EP Learning Health Network project, Solano County would request that the screening tools and materials be made available in English, Spanish and Tagalog. We would also ask that efforts be made to ensure that materials are sensitive to the LGBTQ community.

Description of the Local Community Planning Process

Over the last several years SCBH has engaged in several comprehensive community stakeholder planning processes, including the development of the current MHSA Three-Year Integrated Plan 2017/20, Annual Update FY2017/18, community planning related to the development of the *Solano County Suicide Prevention Strategic Plan,* and most recently community stakeholder meetings for the MHSA Reversion Plan. For all community stakeholder meetings representation included: consumers, family members, mental health and physical health providers, law enforcement, community organizations, educational community, veterans, and representatives from the County's unserved/underserved Latino, Filipino and the LGBTQ communities. Meetings are advertised through the following avenues: email announcements to over 450 community stakeholders; meeting fliers printed in English, Spanish and Tagalog posted in County and Contractor clinic lobbies; ads in the local newspapers in Solano County's major cities; Facebook posts; and posting on the Solano County Mental Health website.

For the most recent community planning process for the MHSA Reversion Plan, which included the EP learning health care network (LHCN) project, stakeholder meetings were held in each of the three major cities Vallejo, Fairfield, and Vacaville and the MHSA Steering Committee was convened. Information was presented to the public related to what local MHSA funds are actually subject to reversion if not spent locally and potential projects that could be considered for funding. The only funds that are subject to reversion are Innovation funds and the two projects endorsed enhance

existing programs or projects. The proposed EP LHCN project enhances the existing local EP direct service program.

In general, the stakeholders were in support of the project and during one meeting, which had strong representation from local education plans, there was a discussion about whether or not the scope of the project could eventually be expanded to have students in middle and high school undergo routine screenings for psychosis using a software app similar to the app being developed for the EP LHCN. While some concerns were raised around local funds being used for a statewide project, the stakeholders responded well to information presented regarding how the project can and will positively impact our community and residents. Stakeholders endorsed the use of self-reporting tools using technology; i.e. the LHCN software app, to evaluate consumers' progress in treatment. During the Public Hearing, Mental Health Advisory Board members emphasized the need for the County and the local EP program to do better outreach to the schools so that students and parents are aware of the program. A suggestion was made to request that all the school districts post a link to educational apps for students that would include information on psychosis.

Total Budget Request by Fiscal Year:

Total budget by fiscal year for the county collaborative portion of the costs.

	FY 18/19 (6 mo)	FY 19/20 (12 mo)	FY 20/21 (12 mo)	FY 21/22 (12 mo)	FY 22/23 (12 mo)	FY 23/24 (6 mo)	TOTAL
Total County Contribution to Collaborative	$42,340	$81,330	$86,037	$85,554	$84,670	$34,280	**$414,211**

Solano County Innovation reversion funds will be used to fund the EP LHCN in the amount of $18,853 for FY18/19 and $26,385 for FY19/20. Costs covered will include county staff time dedicated to the project, the contract with the EP direct service provider, and the contract with UC Davis Behavioral Health Center of Excellence.

Budget Narrative for LHCN and Evaluation:

A detailed budget narrative for the entire county collaborative is described above. Solano county is contributing 3% of the funds in the county collaborative for the LHCN and evaluation. This proportion is based off of county size of all participating LHCN counties.

Budget by Fiscal Year and Specific Budget Category for LHCN and Evaluation for Solano County:

BUDGET CONTEXT - EXPENDITURES BY FUNDING SOURCE AND FISCAL YEAR (FY)								
EXPENDITURES								
		1/1/19-6/30/19	**7/1/19-6/30/20**	**7/1/20-6/30/21**	**7/1/21-6/30/22**	**7/1/22-6/30/23**	**7/1/23-12/31/23**	**1/1/19-12/31/23**
PERSONNEL COSTS (salaries, wages, benefits)		**FY 18/19 (6 mo)**	**FY 19/20 (12 mo)**	**FY 20/21 (12 mo)**	**FY 21/22 (12 mo)**	**FY 22/23 (12 mo)**	**FY 23/24 (6 mo)**	**TOTAL**
1.	Salaries	$1,169	$3,675	$4,104	$4,029	$4,073	$2,203	$19,253
2.	Benefits	$429	$1,425	$1,644	$1,657	$1,761	$982	$7,898
3.	Indirect Costs	$282	$900	$1,014	$1,003	$1,030	$562	$4,791
4.	Total Personnel Costs	$1,880	$6,000	$6,762	$6,689	$6,864	$3,748	$31,943

OPERATING COSTS		FY 18/19 (6 mo)	FY 19/20 (12 mo)	FY 20/21 (12 mo)	FY 21/22 (12 mo)	FY 22/23 (12 mo)	FY 23/24 (6 mo)	TOTAL
5.	Direct Costs							
6.	Indirect Costs							
7.	Total Operating Costs							
NONRECURRING COSTS (equipment, technology)		**FY 18/19 (6 mo)**	**FY 19/20 (12 mo)**	**FY 20/21 (12 mo)**	**FY 21/22 (12 mo)**	**FY 22/23 (12 mo)**	**FY 23/24 (6 mo)**	**TOTAL**
8a.	Direct Costs (Supplies)	$558	$295	$270	$197	$197	$99	$1,616
8b.	Direct Costs (Travel)	$32	$235	$292	$273	$184	$197	$1,211
8c.	Direct Costs (Other)	$6	$38	$6	$38	$6	$6	$101
9.	Indirect Costs	$105.13	$100.26	$100.26	$89.63	$68.37	$53.21	$517
10.	Total Operating Costs	$701	$668	$668	$598	$456	$355	$3,446
CONSULTANT COSTS/ CONTRACTS (clinical training, facilitator, evaluation)		**FY 18/19 (6 mo)**	**FY 19/20 (12 mo)**	**FY 20/21 (12 mo)**	**FY 21/22 (12 mo)**	**FY 22/23 (12 mo)**	**FY 23/24 (6 mo)**	**TOTAL**
11a.	Direct Costs (Subawards)	$6,164	$11,866	$12,461	$12,632	$13,130	$6,407	$62,660
11b.	Direct Costs (Consultant)	$8,742	$6,669	$2,439	$2,005	$803	$390	$21,048
12.	Indirect Costs	$1,542.68	$1,176.91	$430.40	$353.88	$141.69	$68.82	$3,714
13.	Total Consultant Costs	$16,448	$19,712	$15,330	$14,992	$14,075	$6,866	$87,423
OTHER EXPENDITURES (please explain in budget narrative)		**FY 18/19 (6 mo)**	**FY 19/20 (12 mo)**	**FY 20/21 (12 mo)**	**FY 21/22 (12 mo)**	**FY 22/23 (12 mo)**	**FY 23/24 (6 mo)**	**TOTAL**
14.								
15.								
16.	Total Other Expenditures							
BUDGET TOTALS:								
Personnel (salaries and benefits)		$1,598	$5,100	$5,748	$5,685	$5,834	$3,186	$27,152
Direct Costs (consultation, nonrecurring costs)		$15,501	$19,103	$15,468	$15,146	$14,320	$7,099	$86,637
Indirect Costs (15% TC)		$1,930	$2,177	$1,545	$1,447	$1,240	$684	$9,023
TOTAL INNOVATION BUDGET		**$19,029**	**$26,381**	**$22,761**	**$22,278**	**$21,394**	**$10,969**	**$122,812**

Budget Narrative for County Specific Needs:

Mental Health Clinical Supervisor will participate in planning and implementation calls and provide support regarding coordination of the data pulls that will be needed.

IT Analyst IV staff will participate in project calls that are related to data collection and reporting. Additionally, this staff person will export data from the County electronic health record at the beginning of the project in order to pull the baseline data and then will export data a second time towards the end of the project.

Direct Service Contract with a local community-based non-profit organization to provide the Early Psychosis (EP) direct service program.

Budget by Fiscal Year and Specific Budget Category for County Specific Needs

	BUDGET BY FISCAL YEAR AND SPECIFIC BUDGET CATEGORY FOR COUNTY SPECIFIC NEEDS							
	EXPENDITURES							
PERSONNEL COSTS (salaries, wages, benefits)		**FY 18/19 (6 mo)**	**FY 19/20 (12 mo)**	**FY 20/21 (12 mo)**	**FY 21/22 (12 mo)**	**FY 22/23 (12 mo)**	**FY 23/24 (6 mo)**	**TOTAL**
1.	Salaries	12,202	24,404	24,404	24,404	24,404	12,202	122,020
2.	Direct Costs							
3.	Indirect Costs							
4.	Total Personnel Costs	12,202	24,404	24,404	24,404	24,404	12,202	122,020
OPERATING COSTS		**FY 18/19 (6 mo)**	**FY 19/20 (12 mo)**	**FY 20/21 (12 mo)**	**FY 21/22 (12 mo)**	**FY 22/23 (12 mo)**	**FY 23/24 (6 mo)**	**TOTAL**
5.	Direct Costs							
6.	Indirect Costs							
7.	Total Operating Costs							
NONRECURRING COSTS (equipment, technology)		**FY 18/19 (6 mo)**	**FY 19/20 (12 mo)**	**FY 20/21 (12 mo)**	**FY 21/22 (12 mo)**	**FY 22/23 (12 mo)**	**FY 23/24 (6 mo)**	**TOTAL**
8								
9.								
10.	Total Non-recurring Costs							
CONSULTANT COSTS/ CONTRACTS (clinical direct service contract)		**FY 18/19 (6 mo)**	**FY 19/20 (12 mo)**	**FY 20/21 (12 mo)**	**FY 21/22 (12 mo)**	**FY 22/23 (12 mo)**	**FY 23/24 (6 mo)**	**TOTAL**
11a.	Direct Costs	11,109	30,545	38,872	38,872	38,872	11,109	169,379
12.	Indirect Costs							

13.	Total Consultant Costs							
OTHER EXPENDITURES (please explain in budget narrative)		**FY 18/19 (6 mo)**	**FY 19/20 (12 mo)**	**FY 20/21 (12 mo)**	**FY 21/22 (12 mo)**	**FY 22/23 (12 mo)**	**FY 23/24 (6 mo)**	**TOTAL**
14.								
15.								
16.	Total Other Expenditures							
	BUDGET TOTALS:							
Personnel (line 1)		12,202	24,404	24,404	24,404	24,404	12,202	122,020
Direct Costs (add lines 2, 5 and 11 from above)		11,109	30,545	38,872	38,872	38,872	11,109	169,379
Indirect Costs (add lines 3, 6 and 12 from above)								
Non-Recurring costs (line 10)								
Other expenditures (line 16)								
TOTAL INNOVATION BUDGET		23,311	54,949	63,276	63,276	63,276	23,311	**291,399**

Budget Narrative for Total Budget Context- Expenditures by Funding Source and Fiscal Year:
All funds for the county collaborative are planned to come from Innovative MHSA funds.

Total Budget Context- Expenditures by Funding Source and Fiscal Year (FY):

	TOTAL BUDGET CONTEXT- EXPENDITURES BY FUNDING SOURCE AND FISCAL YEAR (FY)							
	ADMINISTRATION:							
A.	**Estimated total mental health expenditures for ADMINISTRATION for the entire duration of this INN Project by FY & the following funding sources:**	**FY 18/19 (6 mo)**	**FY 19/20 (12 mo)**	**FY 20/21 (12 mo)**	**FY 21/22 (12 mo)**	**FY 22/23 (12 mo)**	**FY 23/24 (6 mo)**	**TOTAL**
1.	Innovative MHSA Funds	23,311	54,949	63,276	63,276	63,276	23,311	**291,399**
2.	Federal Financial Participation							
3.	1991 Realignment							
4.	Behavioral Health Subaccount							
5.	Other Funding							
6.	**Total Proposed Administration**	23,311	54,949	63,276	63,276	63,276	23,311	**291,399**
	EVALUATION:							
B.	**Estimated total mental health expenditures for EVALUATION for the entire duration of this**	**FY 18/19 (6 mo)**	**FY 19/20 (12 mo)**	**FY 20/21 (12 mo)**	**FY 21/22 (12 mo)**	**FY 22/23 (12 mo)**	**FY 23/24 (6 mo)**	**TOTAL**

	INN Project by FY & the following funding sources:							
1.	Innovative MHSA Funds	$19,029	$26,381	$22,761	$22,278	$21,394	$10,969	**$122,812**
2.	Federal Financial Participation							
3.	1991 Realignment							
4.	Behavioral Health Subaccount							
5.	Other Funding							
6.	**Total Proposed Evaluation**	$19,029	$26,381	$22,761	$22,278	$21,394	$10,969	**$122,812**
	TOTAL:							
C.	**Estimated TOTAL mental health expenditures (this sum to total for funding requested) for the entire duration of this INN Project by FY & the following funding sources:**	**FY 18/19 (6 mo)**	**FY 19/20 (12 mo)**	**FY 20/21 (12 mo)**	**FY 21/22 (12 mo)**	**FY 22/23 (12 mo)**	**FY 23/24 (6 mo)**	**TOTAL**
1.	Innovative MHSA Funds	$42,340	$81,330	$86,037	$85,554	$84,670	$34,280	**$414,211**
2.	Federal Financial Participation							
3.	1991 Realignment							
4.	Behavioral Health Subaccount							
5.	Other Funding							
6.	**Total Proposed Expenditures**	$42,340	$81,330	$86,037	$85,554	$84,670	$34,280	**$414,211**

Appendix V: Napa County

County Contact and Specific Dates

- Primary County Contact (Name, Email, Phone):
    - Felix A. Bedolla, Project Manager/MHSA Coordinator
    - Felix.Bedolla@countyofnapa.org
    - (707) 299-1759

- Proposed date posted for Local 30-day Public Review and Comment Period: Friday, April 12 – Monday, May 13, 2019
- Proposed date for Napa County Mental Health Board public hearing: Monday, May 13, 2019
- Napa County Board of Supervisors review and adoption: Anticipated in June/July 2019
- Submittal and Review by the Mental Health Oversight and Accountability Commission: Anticipated in July/August 2019

Description of the Local Need

Napa County has approximately 140,973 residents. In Fiscal Year 2017-2018, the Napa County Mental Health Division served an estimated 2910 consumers in FY 17-18. According to Mental Health America, 3.5% of the population experience or will experience psychosis in their lifetime. For Napa County, that would be approximately 4,934 individuals. Numerous studies have shown the significant impact that Early Psychosis programs have to reduce severity of psychosis symptoms in early onset situations as well as improved health outcomes over the long-term. Early Psychosis programs with evidenced-based components and outcomes monitoring can have a positive impact on the well-being of a significant number of consumers.

Napa County and other local funders partner with a local community based organization, Aldea, Inc., which provides effective culturally competent Early Psychosis services through its Supportive Outreach and Access to Resources or SOAR program for Napa County residents ages 8-30 who:

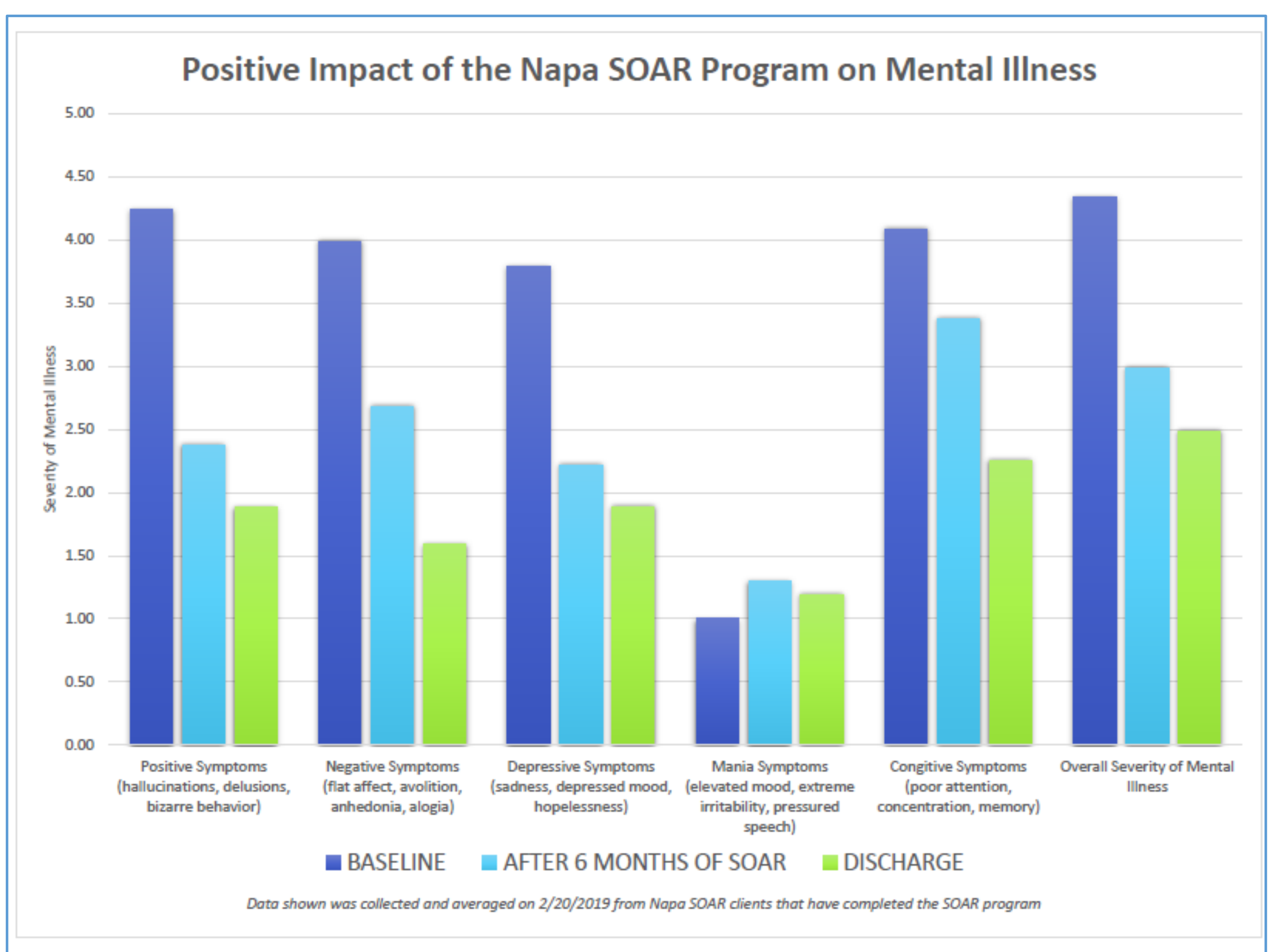
- Have experienced the onset of initial symptoms of psychosis within the 2 years, OR
- Currently have subthreshold symptoms of psychosis (emerging symptoms that indicate the potential onset of psychosis), OR
- Have had a recent deterioration in their ability to cope with stressors and have a parent or sibling with a psychotic disorder

Aldea's SOAR program provides community outreach to local schools, special education programs and service providers to teach staff and volunteers how to identify signs of early psychosis. SOAR also offers treatment services, including:

- Psychiatric medication management
- Individualized clinical case management
- Weekly psychoeducation and support groups
- Weekly multi-family support groups
- Peer advocate support
- Education and employment support

Since its inception in 2014, SOAR has provided services to 64 unduplicated individuals and their

families with an average of 26 unduplicated individuals and their families served per year. SOAR utilizes evaluation tools which include the Clinical Global Impression Scale (CGI - severity of illness & degree of change), as well as the Global Assessment of Functioning (GAF) and Global Functioning - Role (GFR) & Global Functioning - Social (GFS measures, which are administered at baseline, every 6 months and at discharge). The following chart illustrates a reduction in clinical symptoms associated with SOAR program participation. Reduction of scores from an average of 4 (Markedly ill - prominent symptoms with impaired functioning) to a score of 2 or lower (Minimally Ill - few symptoms with minimal impact on functioning) would be seen as clinically meaningful change.



Description of the Response to the Local Need

The proposed project meets a variety of unmet needs across the state:

1. Collects and visualizes consumer-level data across a variety of recovery-oriented measures to directly inform day-to-day service provision. Training and technical assistance will be provided to support the ability for EP program providers to use the LHCN data in practice, transforming these services to measurement-based care.
2. Provides immediate access to relevant outcome data for program leadership that can be quickly shared with stakeholders, the county, or the state. Rapid dissemination of program outcomes has historically been a challenge for county-based programs.

3. Provides infrastructure for an EP Learning Collaborative across counties, in which common challenges can be identified and "lessons learned" can be quickly disseminated, creating a network of programs that rapidly learn from and respond to the changing needs of their consumers and communities.
4. Evaluation of the LHCN will provide information on how to incorporate measurement-based care into mental health services and demonstrate impact of the LHCN on the recipients and providers of EP care.

The Prevention and Early Intervention component of the Mental Health Services Act (MHSA), coupled with a legislative focus on early psychosis (AB 1315, SB 1004), has served as a catalyst for the delivery of early psychosis (EP) services across California. Currently, 23 counties have established Early Psychosis (EP) services using state or federal dollars. Napa County, in collaboration with the UC Davis Behavioral Health Center of Excellence proposes to use Innovation Funds to develop the infrastructure for a sustainable Learning Health Care Network for EP programs. The LHCN project seeks to demonstrate the utility of the network via a collaborative statewide evaluation to clarify the effect of these programs on the clients and communities that they serve. This project, led by UC Davis in partnership with UC San Francisco, UC San Diego, University of Calgary and multiple California counties, will bring client-level data to the clinician's fingertips. This will allow programs to learn from each other through a training and technical assistance collaborative, and position the state to participate in the development of a national network to inform and improve care for individuals with early psychosis across the US.

Through its participation in the LHCN, the Napa County Mental Health Plan and Aldea's SOAR program hope to increase our understanding of the most effective engagement and treatment approaches in order to decrease the duration of untreated psychosis and maximize early detection of psychosis symptoms. There are not yet consistent outcomes measures or reporting approaches for the 28 EPI programs in California; this is the goal of the proposed project of which Napa is seeking to join. Results of the LHCN would enable direct comparison between counties.

Through the EP LHCN's use of electronic tablet data collection; immediate access to participant-level data; use of measures relevant to participants' experience and real-world outcomes; and cost-effectiveness, the Napa County MHP hopes to:

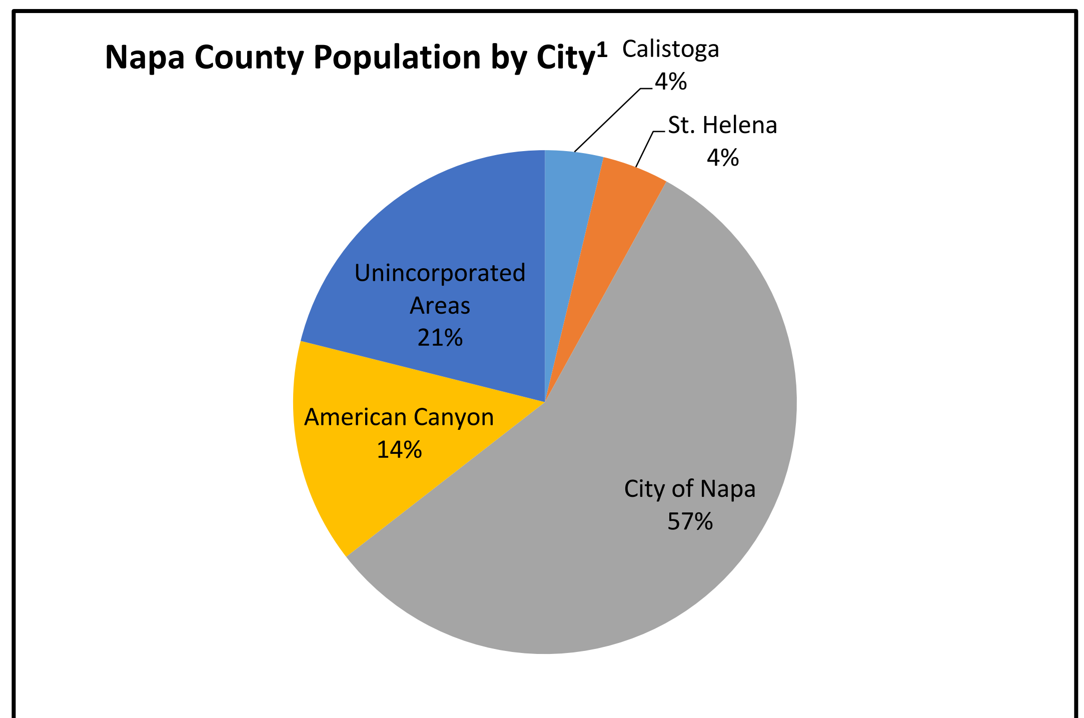
- Improve participant data collection and tracking methods
- Provide timely, effective and efficient service delivery
- Allow clinicians easy access to client-level data
- Offer participants the ability to view their data in real-time
- Engage participants in their treatment and recovery

About Napa County

The Napa Valley, located in the heart of California's pre-eminent wine country is home to some 142,4561 residents who share a strong sense of community and a legacy of preserving and protecting its rich agricultural heritage. The County's strategic location, sunny Mediterranean climate and abundant natural and cultural resources, provides a mix of small town living and city amenities. With its tradition of stewardship and responsible land use planning, Napa County has maintained a strong rural character.

The most common language spoken in Napa, CA other than English is Spanish. 36.1% of Napa, CA Metro Area citizens are speakers of a non-English language. That is higher than the national average of 21%.[1]

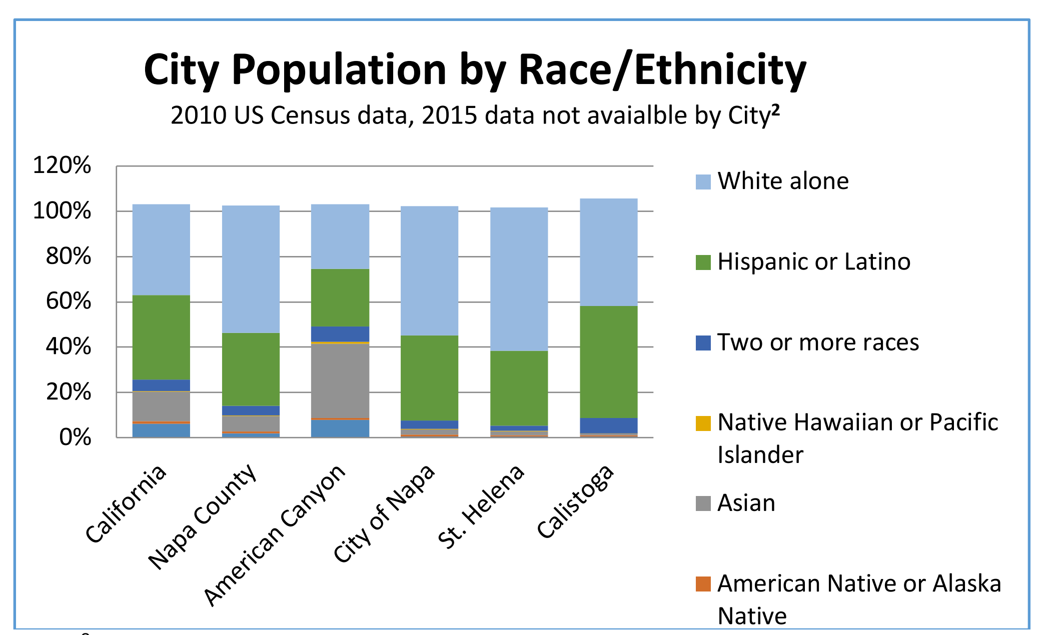
According to 2015 estimates, the population of Napa County is distributed across the County in the following way:



[1] US Census Quick Facts, Napa County Population. April 2017.

Cultural & Linguistic Considerations

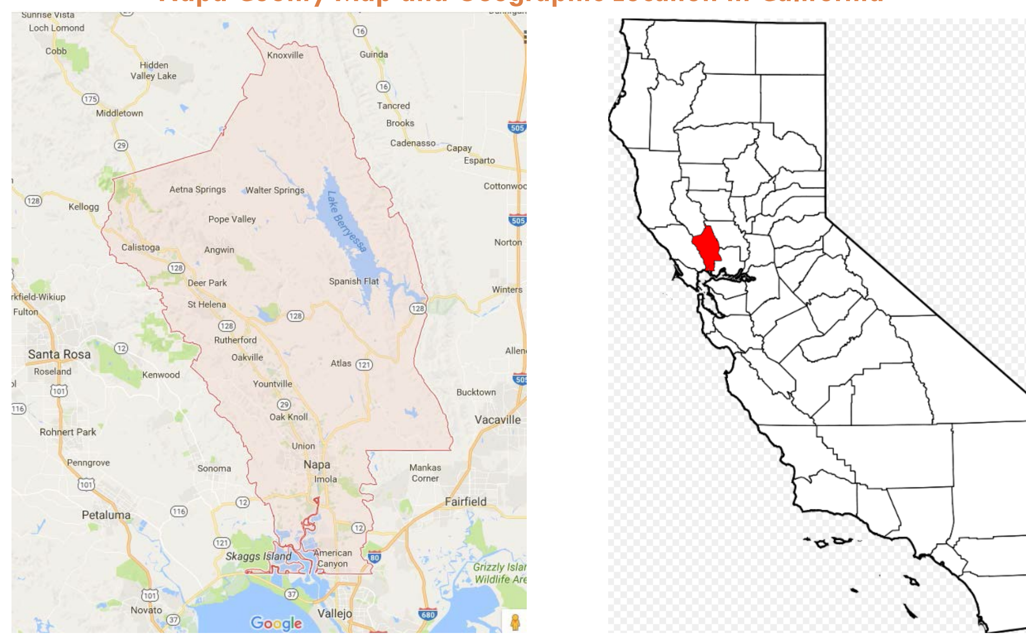
Below is a chart showing the racial/ethnic composition of cities and towns throughout Napa County.



[2] Populations estimates for 2015 US Census Quick Facts, Napa County Population. April 2017

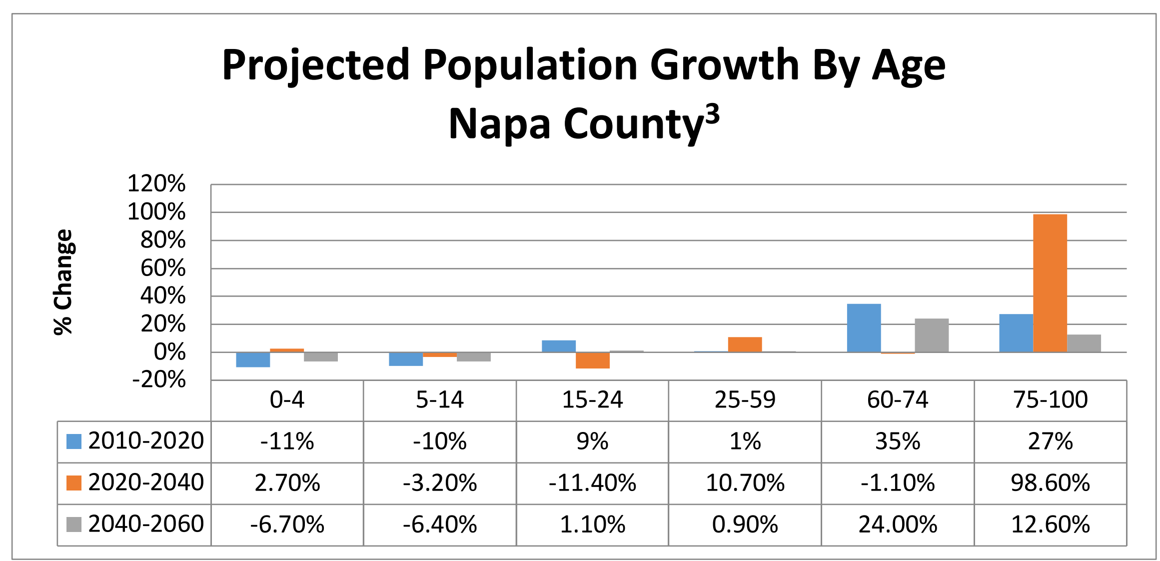
American Canyon is the most diverse city in Napa County and Calistoga continues to have a large population of Hispanic/Latinos, making it the majority racial/ethnic group in the City of Calistoga. The most common non-English languages spoken in Napa County are Spanish and Tagalog.

Napa County Map and Geographic Location in California



Population Projections for Napa County

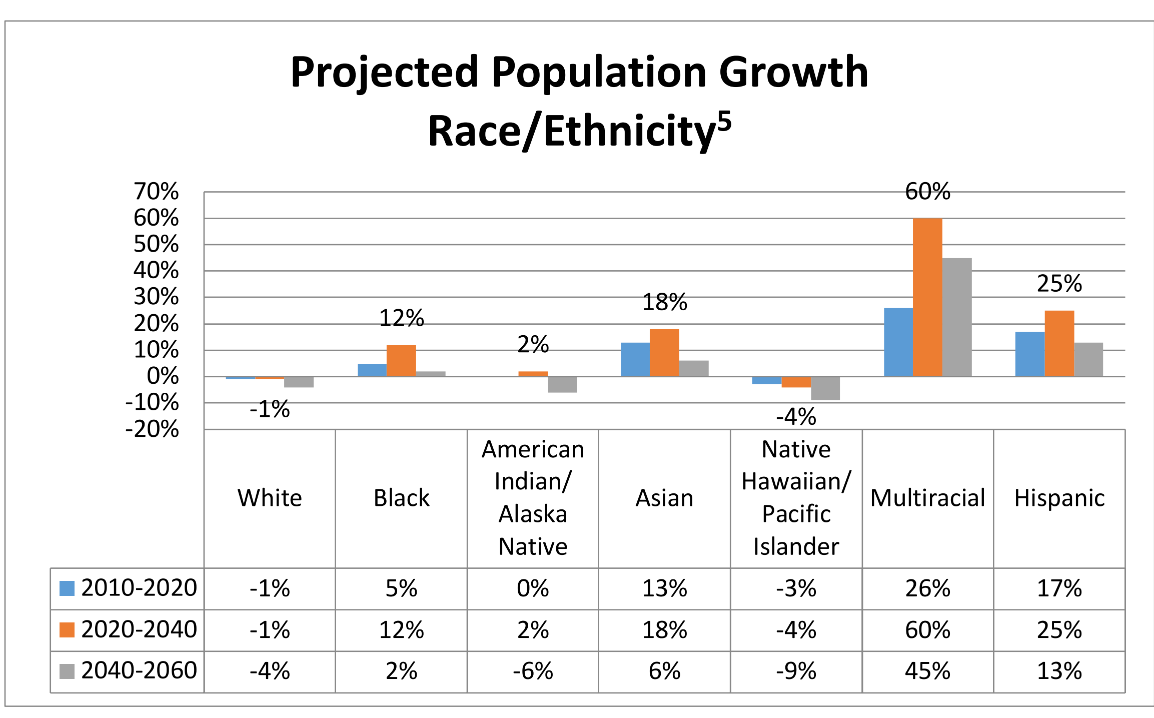
The California Department of Finance (CDF) provides projected population data by age, race/ethnicity[3]. This table shows that while most of the population will remain relatively stable, the age group that will continue to grow at a faster pace will be the 60-74 and 75-100 age group.



	0-4	5-14	15-24	25-59	60-74	75-100
2010-2020	-11%	-10%	9%	1%	35%	27%
2020-2040	2.70%	-3.20%	-11.40%	10.70%	-1.10%	98.60%
2040-2060	-6.70%	-6.40%	1.10%	0.90%	24.00%	12.60%

[3] California Department of Finance Population Projections, April 8, 2017.

CDF data project that the older adult population, particularly the 75+ age range will almost double in the next 20-40 years, while other age groups will have limited growth or slight decreases. While the oldest age groups are the fastest growing in the county, there is currently no evidence based intervention model for working with psychosis in older adults, which is often associated with dementia and other medical comorbidities. The Napa SOAR program uses evidence based approaches for youth who are in the age range of highest risk for primary psychotic illness. Hispanic, Asian, and Multiracial populations will continue to grow in the County.



	White	Black	American Indian/ Alaska Native	Asian	Native Hawaiian/ Pacific Islander	Multiracial	Hispanic
2010-2020	-1%	5%	0%	13%	-3%	26%	17%
2020-2040	-1%	12%	2%	18%	-4%	60%	25%
2040-2060	-4%	2%	-6%	6%	-9%	45%	13%

[5] (Source: http://www.california-demographics.com/napa-county-demographics#)

Description of the Local Community Planning Process

Local Stakeholder Participation and Engagement

The Napa Mental Health Plan has been working collaboratively with our local Mental Health Stakeholder Advisory Committee (SAC) since 2005. SAC members meet on a monthly basis and continue to provide guidance and program monitoring through review of program evaluation, program design and budget allocations.

The SAC is the primary stakeholder body that is involved in the Mental Health Plan's MHSA Community Program Planning Process and is composed of:

- Chief Probation Officer for Adult and Juvenile Probation representing Law Enforcement
- Consumers and Family Members Representatives
- Representative from Napa Valley Unified School District representing K-12 Education
- Representative from Napa County Office of Education representing K-12 Education
- Representative from Napa Valley College representing Higher Education
- Representatives from the Behavioral Health Committee representing Community Mental Health Service Providers and the Napa Valley Non-Profit Coalition
- Representative from the Napa County Commission on Aging representing Older Adults and the Napa County Mental Health Board
- Representative from the Healthy Aging Population Initiative (HAPI) representing Older Adults
- Representative from Parent-Child Action Network (ParentsCAN) representing family members
- Representative from Napa County Public Health Division representing Health providers
- Representative from Napa County's Alcohol and Drug Services Division representing Substance Abuse Services, Co-Occurring, Prevention and Youth
- LGBTQ Program Coordinator from a local non-profit organization representing the LGBTQ community
- Director of a local inter-tribal organization representing the Native American community

- The Director, Clinical Director and MHSA Staff of the Mental Health Plan

Mental Health Division Staff and SAC members are working to recruit additional committee members to fill the following vacancies:

- TAY Representative
- Faith Community Representative
- Latino Community Representative
- Veterans Representative
- Asian/Pacific Islander Representative

The SAC participates in all stages of the planning process. They will also work with the County to ensure that their constituencies receive the information necessary to be able to give input and participate in the planning process.

In May 2018, the MHP began participating in statewide conference calls regarding potential participation in the University of California at Davis Collaborative Statewide Early Psychosis (EP) Learning Health Care Network (LHCN). Staff discussed the potential participation in the 2nd Cohort for EP LHCN with the SAC in September 2018 using Innovations Round 3 funding. SAC members were supportive of this concept.
MHP staff will be meeting with the Executive Committee of the Mental Health Board to discuss participation in this project in late February to request a public hearing at the end of the proposed public review and comment period.

Public Review and Comment Period/Public Hearing
The proposed 30-day Public Review and Comment Period for the MHP's Innovations Round 3 Project – Participation in the UC Davis EP LHCN Collaborative, is anticipated to take place from Friday, April 12 to Monday, May 13, 2019. MHP staff will request a public hearing at a regular meeting of the Napa County Mental Health Board on Monday, May 13, 2019 from 4-6 pm in compliance with California Code of Regulations (CCR) 3315(a)(b). During the public review/comment period, the Division's Proposed Innovations Round 3 Project: Participation in the UC Davis EP LHCN Collaborative will be posted to community bulletin boards and emailed to all MHSA stakeholders. It will also be posted to the MHP's website, and available to all interested parties at the Mental Health Division office at 2751 Napa Valley Corporate Drive, Bldg. A., in Napa upon request. All community stakeholders will be invited to participate in the public review/comment process.

Total Budget Requested by Fiscal Year:

The total budget by fiscal year for includes Napa County's collaborative portion of the costs at a rate of 0.008191 of total LHCN Project costs and County Specific Costs for Napa County and Aldea staff to participate in the LHCN Project.

	FY 19/20 (12 mo)	FY 20/21 (12 mo)	FY 21/22 (12 mo)	FY 22/23 (12 mo)	FY 23/24 (12 mo)	TOTAL
Total County Contribution to Collaborative	$51,679	$48,935	$53,358	$53,740	$50,768	**$258,480**

Budget Narrative for LHCN and Evaluation:

Working with the LHCN's evaluators, Napa County will carefully review the outcomes of this program to determine if this project is viable to continue after the completion of the project.

BUDGET EXPENDITURES BY FISCAL YEAR (FY) FOR NAPA COUNTY PARTICIPATION IN LHCN AT .8191% OF TOTAL PROJECT COSTS							
EXPENDITURES							
		7/1/19-6/30/20	**7/1/20-6/30/21**	**7/1/21-6/30/22**	**7/1/22-6/30/23**	**7/1/23-12/31/23**	**7/1/19-12/31/23**
PERSONNEL COSTS (salaries, wages, benefits)		**FY 19/20 (12 mo)**	**FY 20/21 (12 mo)**	**FY 21/22 (12 mo)**	**FY 22/23 (12 mo)**	**FY 23/24 (6 mo)**	**TOTAL**
1.	Salaries	$1,564	$1,325	$1,301	$1,315	$712	$6,218
2.	Benefits	$599	$531	$535	$569	$317	$2,551
3.	Indirect Costs	$382	$328	$324	$333	$182	$1,547
4.	Total Personnel Costs	$2,545	$2,184	$2,160	$2,217	$1,210	$10,316
OPERATING COSTS		**FY 19/20 (12 mo)**	**FY 20/21 (12 mo)**	**FY 21/22 (12 mo)**	**FY 22/23 (12 mo)**	**FY 23/24 (6 mo)**	**TOTAL**
5.	Direct Costs						
6.	Indirect Costs						
7.	Total Operating Costs						
NONRECURRING COSTS (equipment, technology)		**FY 19/20 (12 mo)**	**FY 20/21 (12 mo)**	**FY 21/22 (12 mo)**	**FY 22/23 (12 mo)**	**FY 23/24 (6 mo)**	**TOTAL**
8a.	Direct Costs (Supplies)	$276	$87	$64	$64	$32	$522
8b.	Direct Costs (Travel)	$86	$94	$88	$59	$63	$391
8c.	Direct Costs (Other Directs)	$14	$2	$12	$2	$2	$33
9.	Indirect Costs	$66	$32.38	$28.95	$22.08	$17.18	$167
10.	Total Operating Costs	$442	$216	$193	$147	$115	$1,113
CONSULTANT COSTS/ CONTRACTS (Clinical Training, Facilitator, Evaluation)		**FY 19/20 (12 mo)**	**FY 20/21 (12 mo)**	**FY 21/22 (12 mo)**	**FY 22/23 (12 mo)**	**FY 23/24 (6 mo)**	**TOTAL**
11a.	Direct Costs (Subawards)	$5,822	$4,024	$4,079	$4,240	$2,069	$20,235
11b.	Direct Costs (Consultants & App)	$4,977	$788	$648	$259	$126	$6,797
12.	Indirect Costs	$878	$138.99	$114.28	$45.76	$22.22	$1,200
13.	Total Consultant Costs	$11,677	$4,951	$4,841	$4,545	$2,217	$28,232
OTHER EXPENDITURES (please explain in budget narrative)		**FY 19/20 (12 mo)**	**FY 20/21 (12 mo)**	**FY 21/22 (12 mo)**	**FY 22/23 (12 mo)**	**FY 23/24 (6 mo)**	**TOTAL**
14.							
15.							
16.	Total Other Expenditures						
BUDGET TOTALS:							
Personnel (salaries and benefits)		$2,163	$1,856	$1,836	$1,884	$1,029	$8,768
Direct Costs (consultation, nonrecurring costs)		$11,175	$4,995	$4,891	$4,625	$2,292	$27,979
Indirect Costs (15% TC)		$1,326	$499	$467	$400	$221	$2,914
TOTAL INNOVATION BUDGET		**$14,665**	**$7,350**	**$7,194**	**$6,909**	**$3,542**	**$39,661**

Budget Narrative for County Specific Needs:

Personnel Description

(Periods are 6 months each. Assumes census of 50 clients/program, with assessments at baseline, 6-months, and 12-months (2-3 assessments per person). For 250 assessments and a 25% no show rate that makes 200 assessments over 40 work weeks (with holidays/vacations) averaging out to ~5 assessments per week or 1 assessment per day.)

<u>Napa County Mental Health Division Staff</u>

Data Support Person – Staff Services Analyst II:
The county data person will perform two data pulls during the course of the five-year project. Data will be for EP and comparator program utilization and contracted costs, ED and hospital utilization and costs, and other data as available (e.g. IOP/PHP costs, justice involvement). They will participate in bi-weekly consultation meetings to harmonize data systems and identify variables. It is anticipated that each pull will take 40 hours at two time points (once at the end of Year 2, and once at the end of Year 4).
Years 1-5: .05 FTE

Administrative Leadership Person – Mental Health Manager:
The county administrative support person will participate in monthly meetings with the evaluation team as well as biweekly meetings EP and comparator program leadership for problem solving. They would also participate in quarterly meetings with other counties as part of the learning health care network.
Years 1-5: .05 FTE

<u>Aldea Program Staff</u>

Early Psychosis Program Manager/Administrator – Program Director
The program manager will attend monthly project meetings and quarterly Learning Health Care Network meetings. They will also meet weekly with program support staff to ensure task completion to meet project goals. They will oversee the fidelity evaluation at their site.
Years 1-5: .05 FTE (Average 2 hours per week)

EP Program Support Person – Intake Coordinator:
The program support person will participate in monthly project meetings and weekly meetings with program manager. They will schedule meetings associated with qualitative data collection at their site, including meetings with client/family, program, and county stakeholders. They will provide administrative support for the fidelity evaluation at their site, including scheduling of site meetings and health record abstraction (est. 1 hr per chart for 10 charts). They will the administer tablets to clients 3 times per year, roughly one assessment per day accounting for a 25% no show rate, for every 50 clients.

Year 1-Year 2: Period 1: .10 FTE (Average 4 hours per week)
Year 2: Period 2- Year 5 .25 FTE (Average 2 hours/day per week)

Budget by Fiscal Year and Specific Budget Category for County Specific Needs:

BUDGET EXPENDITURES BY FISCAL YEAR (FY) FOR NAPA COUNTY COSTS							
EXPENDITURES							
		7/1/19-6/30/20	**7/1/20-6/30/21**	**7/1/21-6/30/22**	**7/1/22-6/30/23**	**7/1/23-12/31/23**	**7/1/19-12/31/23**
PERSONNEL COSTS (salaries, wages, benefits)		**FY 19/20 (12 mo)**	**FY 20/21 (12 mo)**	**FY 21/22 (12 mo)**	**FY 22/23 (12 mo)**	**FY 23/24 (6 mo)**	**TOTAL**
1.	Salaries (2% COLA per year included)						
	County - MH Manager ($128,204/yr)	$6,410	$6,538	$6,669	$6,803	$6,939	$33,359
	County - Staff Services Analyst ($89,406/yr)	$4,470	$4,560	$4,651	$4,744	$4,839	$23,264
	Aldea - Program Director ($80,000/yr)	$4,000	$4,000	$4,000	$4,000	$4,000	$20,000
	Aldea - Intake Coordinator ($38,459/yr)	$3,846	$6,730	$9,615	$9,807	$9,807	$39,805
2.	Benefits						
	County - MH Manager ($63,740.22/yr)	$3,187	$3,251	$3,316	$3,382	$3,450	$16,585
	County - Staff Services Analyst ($50,615.64/yr)	$2,531	$2,581	$2,633	$2,686	$2,739	$13,170
	Aldea - Program Director ($24,000/yr)	$1,200	$1,200	$1,200	$1,200	$1,200	$6,000
	Aldea - Intake Coordinator ($11,537.70/yr)	$1,154	$2,019	$2,884	$2,942	$2,942	$11,942
3.	Total Personnel Costs	$26,798	$30,880	$34,968	$35,563	$35,916	$164,125
OPERATING COSTS		**FY 19/20 (12 mo)**	**FY 20/21 (12 mo)**	**FY 21/22 (12 mo)**	**FY 22/23 (12 mo)**	**FY 23/24 (6 mo)**	**TOTAL**
4.	Direct Costs (21%)	**$ 7,000**	**$ 7,000**	**$ 7,000**	**$ 7,000**	**$ 7,000**	**$ 35,000**
5.	Indirect Costs (12%)	**$ 3,216**	**$ 3,706**	**$ 4,196**	**$ 4,268**	**$ 4,310**	**$ 19,695**
6.	Total Operating Costs	**$ 10,216**	**$ 10,706**	**$ 11,196**	**$ 11,268**	**$ 11,310**	**$ 54,695**
CONSULTANT COSTS/ CONTRACTS (clinical training, facilitator, evaluation)		**FY 19/20 (12 mo)**	**FY 20/21 (12 mo)**	**FY 21/22 (12 mo)**	**FY 22/23 (12 mo)**	**FY 23/24 (6 mo)**	**TOTAL**
7.	Direct Costs (Subawards)						
8.	Direct Costs (Consultants & App)						
9.	Indirect Costs						
10.	Total Consultant Costs						
BUDGET TOTALS:							
Personnel (salaries and benefits)		**$26,798**	**$30,880**	**$34,968**	**$35,563**	**$35,916**	**$164,125**
Direct Costs (consultation, nonrecurring costs)		**$7,000**	**$7,000**	**$7,000**	**$7,000**	**$7,000**	**$35,000**
Indirect Costs		**$3,216**	**$3,706**	**$4,196**	**$4,268**	**$4,310**	**$19,695**
TOTAL COUNTY EXPENDITURES		**$37,014**	**$41,585**	**$46,164**	**$46,831**	**$47,226**	**$218,820**
NAPA COUNTY LHCN CONTRIBUTIONS		**$14,665**	**$7,350**	**$7,194**	**$6,909**	**$3,542**	**$39,660**
TOTAL INNOVATION PROJECT EXPENDITURES		**$51,679**	**$48,935**	**$53,358**	**$53,740**	**$50,768**	**$258,480**

Appendix VI: Sonoma County

County Contact and Specific Dates

- Primary County Contact (Name, Email, Phone):
  - Melissa Ladrech, Project Manager/MHSA Coordinator
  - Melissa.Ladrech@Sonoma-County.org
  - Office: 707.565.4909 Mobile: 707.387.2691
- Proposed date for posting for local 30-day Public Review and Comment Period:
  - Monday, April 27, 2020 – Wednesday, May 27, 2020
- Proposed date for posting for local MH Board hearing:
  - Wednesday, May 27, 2020
- Proposed date to send to MHSOAC
  - Monday, June 1, 2020
- Proposed date of BOS review and approval:
  - Tuesday, June 9, 2020

Description of the Local Need Add

Sonoma County measures 1,576 square miles and is the largest and northernmost county in the San Francisco Bay Area. In 2017, Sonoma County had the 17th largest county population of the 58 counties in California, with an estimated 504,217 residents (approximately 319 people per square mile).[2] According to 2017 Department of Finance population estimates, Santa Rosa - the county seat and most populated city - is home to about 35% of the total population and ranks as the 25th largest city in the state.[3] The majority (68%) of Sonoma County residents live within nine separate cities, with the remainder living within the unincorporated areas of the county. Sonoma County's population grew 4% from 483,880 people in 2010 to 504,217 in 2017.

Psychotic illness is a major public health issue, devastating individuals, families and society. Although the causes are not completely understood, the first psychotic episode typically occurs in youth and young adults. Hallucinations and delusions are characteristic features of psychosis, but it can also result in a lack of motivation, inability to think clearly, tremendous social stigma, and high rates of substance abuse and homelessness, often leading to suicide. Locally, the recent MHSA Capacity Assessment, 2016-2019 for Sonoma County reported a gap in community knowledge in how to access the mental health system of care, potentially creating delays for those in need. Some family members reported feeling "lost" at the initial stage of their loved one's mental illness. They were often leading the process and were unsure if they should seek services and did not know who to ask for support with such a major decision. Sometimes this resulted in **waiting to seek help until their loved one experienced a crisis**, which they felt could be prevented by having more education about mental illness and information on the resources available. For those that knew they wanted to access services, many reported not knowing where to go to learn about Sonoma County's behavioral health system generally, or specific services and providers. Some stakeholders reported taking a long time to figure out what steps to take to help their loved one and noted the adverse emotional impact of not being able to provide immediate support.[4]

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[2] U.S. Census Bureau, 2017 American Community Survey 1-Year Estimates. Table S0501. Retrieved March 2019. https://factfinder.census.gov/faces/tableservices/jsf/pages/productview.xhtml?pid=ACS_16_1YR_S0501&prodType=table

[3] California Department of Finance - E-1 Population Estimates for Cities, Counties, and the State — January 1, 2017 and 2018. http://www.dof.ca.gov/Forecasting/Demographics/Estimates/E-1/

[4] Research Development Associates, Sonoma County Mental Health Services Act FY 2016-2019 Capacity Assessment.

The service delays described above may have led to an increased use of crisis services. There exists a high level of need among consumers in Sonoma compared to other California counties. Many residents used crisis services through the Crisis Stabilization Unit (CSU), inpatient hospitals, and emergency departments. In fiscal year 2018-2019, about 2,000 consumers went to the **Crisis Stabilization Unit (CSU) over 2,500 times**, and many stayed longer than the expected 24-hour period.[5] Additionally, the California External Quality Review Organization (CalEQRO), Behavioral Health Concepts (BHC), found a **high level of psychotic disorder (29%) among Medi-Cal beneficiaries in Sonoma County** compared to California residents overall (16%).[6]

Based on an average incidence of psychotic illness of 272 per 100,000 people each year, approximately 434 Sonoma County residents are estimated to experience a first psychotic episode each year.[7] However, presently there are no Coordinated Specialty Care programs or similarly modeled services in Sonoma County for youths.[8] This need statement came from a request for proposal recently released by the One Mind organization. Through a partnership with Kaiser Permanente and the Elizabeth Morgan Brown Memorial Fund, One Mind requested proposals to establish a treatment program in Sonoma County aimed at promoting recovery in youth at risk for or living with early-stage psychotic illnesses, such as schizophrenia, bipolar disorder, or major depressive disorder with psychotic features. The Elizabeth Morgan Brown Memorial Fund was created by David and Seong Brown to honor the memory of their daughter, Elizabeth, who took her own life at the age of 19 after years of battling depression and anxiety.

When surveyed by the California Behavioral Health Planning Council for the 2018 Sonoma County Data Book, county behavioral health representatives identified underserved populations and unmet mental health needs. Among them were pre-crisis and crisis services for children, youth and young adults. In addition, a variety of barriers were cited: lack of specialized professional expertise, geographic access and lack of transportation, and lack of language and cultural competencies. Finally, the community identified the need for case management, rehabilitation and vocational services.

The lack of early psychosis intervention services in Sonoma County and the inconsistency of mental health services across counties was highlighted in 2019 when Sonoma County resident, Brighid FitzGibbon's son, Evan, entered a catatonic state. Acute psychosis had hit suddenly a few weeks earlier, toward the end of fall semester of his sophomore year at Bard College. Gripped by terrifying delusions, his body began to shut down. Brighid and her husband rushed their 20-year-old son to a Sonoma County hospital, where they live. An acquaintance told them of a promising program for young people experiencing early psychosis. The family quickly discovered the program didn't exist in their county.[9]

With an established need for an early psychosis intervention program in Sonoma County, it follows suit that providing a program that incorporates best practices, is implemented with fidelity and has a strong data collection and evaluation plan is ideal. Sonoma County, in partnership with Buckelew Programs, Aldea Children and Family Services, On the Move/VOICES seeks to join the Early Psychosis Learning Health Care Network collaborative led by University of California, Davis. While there are currently 30 active programs providing early psychosis (EP) services across 26 counties, there is no uniformity across the state in EP

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[5] Ibid

[6] CalEQRO, BHC. (2019). FY 2018-19: Medi-Cal specialty mental health external quality review: Sonoma MHP final report. Emeryville, CA.

[7] Radigan, M., Gu, G., Frimpong, E. Y., Wang, R., Huz, S., Li, M., ... & Dixon, L. (2019). A new method for estimating incidence of first psychotic diagnosis in a Medicaid population. Psychiatric Services, 70(8), 665-673.

[8] Research Development Associates, Sonoma County Mental Health Services Act FY 2016-2019 Capacity Assessment.

[9] June 23, 2019, 'Treatment for Psychosis – and Other Mental Illness – Differs Drastically from the County of Lost Coast Outpost'; Vaaju.com

service implementation. To address this issue, the innovative Early Psychosis Learning Collaborative's goal is to create a unified network of CA EP providers to standardize best practices and support knowledge-sharing[10].

Description of the Response to the Local Need

Through a collective impact partnership, the Elizabeth Morgan Brown One Mind ASPIRe Program of Sonoma County strives to pool resources to improve health outcomes for Sonoma County's youth. Buckelew is the lead agency in this collaborative project bringing together three organizations: Buckelew Programs, Aldea Children and Family Services, and On the Move/VOICES. Together we will establish the first ever treatment program for youth psychosis in Sonoma County. Collectively, we have the necessary experience to provide direct mental health services, case management, outreach, education, and support services. We are also seeking to participate in one of the innovation projects, the Statewide Early Psychosis Learning Collaborative. Our partner, Aldea Children and Family Services, is already a member of the Collaborative through their Early Psychosis Intervention Programs in Solano and Napa Counties, and we plan to bring Sonoma County into it with this new project.

Buckelew Programs has a Medi-Cal certified site in Sonoma County that is open and operational, and for this program will provide Supported Education and Employment (SEE) Services, Parent Partner, Family Support, and participate in all outreach activities. Buckelew has a long history of serving youth, has close collaborative relationships with many youth serving organizations, and provides Family Service Coordination for families of individuals experiencing mental Illness. This program provides essential navigational skills to family members, offering support and resources, especially when families are first confronted with a loved one's diagnosis. Families often need immediate support, compassion, and a knowledgeable person to help them access the appropriate level of service. This is key to ensure youth are engaged in treatment at the onset of symptoms and not in the midst of a crisis. We seek to create a system that is not a "fail first" system, but one that identifies and provides intervention early on in the course of a diagnosis.

Aldea has trained with UC Davis since February of 2014 in the Early Diagnosis and Preventive Treatment (EDAPT) Program model of treatment and is an experienced provider of the SOAR EDAPT program in Solano and Napa Counties. With their knowledge and clinical expertise, they will be responsible for Comprehensive Eligibility Assessment, Comprehensive Psychiatric Assessment, Intensive Case Management, Psychoeducation, Supported Education and Employment, Medication Management, Individual and Family Psychotherapy using Cognitive Behavioral Therapy, and Groups, such as Multi-Family (problem solving), and Substance Abuse Management. Aldea has 5-years of experience working with UC Davis on EDAPT programs.

VOICES/On the Move will provide Peer Advocate Support and multi-family group support. VOICES Sonoma boasts ten-years of experience engaging diverse, transition-age youth in comprehensive services. During this time, VOICES has worked to develop a strong partnership with the Behavioral Health Division and the Family, Youth & Services Division of Sonoma County Human Services. In 2016, VOICES began providing the Alchemy Project in Sonoma County for youth identified as having a serious mental disorder, and adults 18-25 who have had First Episode Psychosis and are at imminent risk of decompensation.

A secondary, but no less crucial, element in our proposed collaborative project is the enhancement of the Parent Partner component of the program. A Parent Partner is a clinically supervised paraprofessional who has raised a child with a mental, emotional, or behavioral disorder. They understand the challenges that come with raising children with special needs. The purpose of the Parent Partner is to provide active, hands-on peer support to parents/caregivers of youth receiving services. The Parent Partner also works collaboratively with program staff to support systems of change by increasing family involvement and decreasing unintentional bias about parents. The Parent Partner component of the program will be enhanced through the increase of staff time.

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[10] Memorandum from MHSOAC to MHSA Coordinators, March 2019.

The population to be served by this program are individuals at increased risk or in the early stages of a psychotic disorder as well as their family members, caregivers, or other support persons. Individuals are ages 12-30 years old, with any of the following criteria: onset of psychosis within the past two years OR attenuated psychotic symptoms (of any duration) OR recent deterioration in youth with a parent/sibling with psychotic disorder. We also serve Mood/Bipolar Disorder with attenuated psychotic symptoms of any duration OR fully psychotic features with onset in the past two years. The program is expected to serve approximately 300 individuals per year. It is anticipated that approximately 200 individuals will participate in education and outreach activities; 60 individuals will participate in screening; 40 individuals will undergo a complete assessment and 40 individuals will be provided treatment services and 80% of the individuals enrolled as clients in the program will be provided employment and education services. These numbers are based on our partner agency Aldea's experience with providing early psychosis intervention in Solano County, a count of a similar size.

Cultural & Linguistic Competency

The Sonoma County Mental Health Services Act (MHSA) Program and Expenditure Plan Annual Update for 2019-2020 And Annual Program Report for 2017-2018 states:

"Although the racial/ethnic composition is changing, Sonoma County is still substantially less diverse than the state as a whole. In 2017, 64% of Sonoma County residents were White/Caucasian, non-Hispanic or Latino; 27% were Hispanic or Latino, 5% were Asian or Pacific Islander, 2% were African American, and 2% were American Indian or Alaska Native. An estimated 17% of Sonoma County residents were foreign born. The total Hispanic or Latino population increased by over 300% in the past 20 years and is projected to grow at a rate three times faster than the overall population in Sonoma County. By 2060, the Hispanic or Latino population is estimated to increase by approximately 100,000 people. This increase has cultural and linguistic implications with regards to designing effective governmental programs and community-based initiatives."

The need for linguistically and culturally competent services is clearly illustrated by the percentage of Latino/Hispanic Medi-Cal enrollees in Sonoma County. The California External Quality Review Organization (CalEQRO), BHC Behavioral Health Concepts, reports that Sonoma County's average monthly unduplicated number of Medi-Cal enrollees by Race/Ethnicity during Calendar Year 2017 are as follows:

Of a total of 129,596 enrollees, 53,672 (or 41.4%) were Latino/Hispanic, followed by 46,153 (or 35.6%) White. The remaining numbers were comprised of Asian/Pacific Islander (4,899 or 3.8%), African American (2,438 or 1.9%), Native American (1,675 or 1.3%), and 20,760 (or 16%) "Other".[11]

Based on this data, California's Department of Health Care Services (DHCS) Information Notice 13-09 reports Spanish as a threshold language for Sonoma County. DHCS defines "Threshold Language" as a language identified as the primary language, as indicated on the Medi-Cal Eligibility Data System (MEDS), of 3,000 beneficiaries or five percent of the beneficiary population, whichever is lower, in an identified geographic area, per Title 9, CCR Section 1810.410 (a)(3).

Buckelew Programs' goal is to effectively and equitably serve every client, regardless of race, spiritual beliefs, ethnicity, national origin, gender, age, sexual orientation, cultural beliefs, language, socio-economic status or degree of acculturation, and will tailor program services to meet the cultural and linguistic needs of each client.

The Elizabeth Morgan Brown One Mind ASPIRe Program of Sonoma County will be consistent with the National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care (the National CLAS Standards) which are intended to advance health equity, improve quality, and help eliminate health care disparities by providing a blueprint for individuals and health care

[11] Sonoma County Mental Health Services Act (MHSA) Program and Expenditure Plan Annual Update for 2019-2020 And Annual Program Report for 2017-2018

organizations to implement culturally and linguistically appropriate services. This approach includes hiring and retention practices to establish and maintain a diverse workforce, by ensuring there are qualified bilingual staff and/or interpreters in its services delivery for appropriate evaluation, diagnosis, treatment, and referral to additional services. All written informational materials and treatment plans are available in the County's threshold language of Spanish for Spanish preferred clients and/or family members. *LanguageLine*© interpretation services are available at all Buckelew program sites.
To ensure cultural competence at the individual employee level, Buckelew works with employees to increase their awareness of their own cultural values and how that may affect work with clients and colleagues. This includes understanding there are differences among cultural groups and being aware of their own personal stereotypes and biases. Buckelew works closely with employees to assist them in acquiring the ability and skills to engage with clients from different cultures, and encourages them to explore personal understanding, stereotypes and ideas in order to evaluate how he/she could be more effective working in a diverse community. Respect and openness allow clients to share their beliefs, values, and cultural orientation so that staff can provide the best services possible.
At the organizational level, leadership treat staff with the same respect for cultural diversity as is expected of service to diverse clients. For the Elizabeth Morgan Brown One Mind ASPIRe Program of Sonoma County, Buckelew will establish a cultural competence committee that includes a wide variety of membership; they will use the demographic information collected to evaluate how effectively the organization's structure is reflecting the community and the client.
Additionally, a minimum of four hours per year of cultural competency training is required for Buckelew staff. Buckelew Programs' cultural competency committee is currently working on a training plan that will deepen and expand our offerings in this area to include opportunities to learn from culturally diverse community partners in our service area as well as incorporate learning and development opportunities in regular staff meetings.

Description of the Local Community Planning Process

In 2019, Sonoma County initiated a new round of Innovation projects with the support of the MHSA Steering Committee and the Committee's Innovation subcommittee. The Innovation subcommittee were responsible for the following:

1. Determining a community engagement process for the Innovation Project 2020;
2. Assuring the regulations, defined parameters and principles of the MHSA Innovation are adhered to in the process;
3. Support the selection of the Innovation Project(s) that address the county's prioritized need/gaps.

The following chart documents the work of the MHSA Steering Committee and the Innovation Subcommittee through Fiscal Years 2018-2019 and 2019-2020.

Date	Who	Action
Fiscal Year 2018-2019		
Apr 22	MHSA Steering Committee	Reviewed MHSA Innovation regulations and Toolkit; recruited Innovation Subcommittee members; discussed county priorities/needs
May 14	MHSA Coordinator, MHSA Consultant, Innovation Subcommittee	First meeting: review roles/responsibilities, calendar, review and prioritize community needs/gaps in mental health services. Determine data required to substantiate need.

Jun 12	MHSA Coordinator, MHSA Consultant, Innovation Subcommittee	Adopt community engagement model to solicit program models that address needs/gaps.
Fiscal Year 2019-2020		
Jul 10	MHSA Coordinator, MHSA Consultant, Innovation Subcommittee	Develop Innovation application and evaluation criteria for proposals
Aug 14	MHSA Coordinator, MHSA Consultant, Innovation Subcommittee	Review and approve final application and evaluation criteria for community submissions/applications
Aug 19	MHSA Coordinator	Announce Innovation opportunity to public, post Innovation application and evaluation criteria on Department website.
Aug 21	Mental Health Board Public Hearing MHSA Coordinator	Review progress on Innovation project update report
Sep 9	MHSA Steering Committee	Innovation Subcommittee provide Innovation project update report to Steering Committee including: application, scoring criteria, FAQs; community outreach and important dates
Sep 4 – 13	MHSA Coordinator, MHSA Consultant, Innovation Subcommittee	Conduct five community meetings in strategic geographic locations to share Innovation project guidelines, application and evaluation criteria with interested community members
Oct 18	Community	Deadline for Innovation applications
Oct 25 & Nov 8	MHSA Coordinator, MHSA Consultant, Innovation Subcommittee	Review and score Innovation applications, two meetings held to discuss scores and rank proposals, developed recommendation for funding based on ranking
Dec 2	MHSA Steering Committee	Innovation Subcommittee recommendation for funding to MHSA Steering Committee and BHD administration.
Feb 18	Sonoma County Mental Health Board Public Meeting MHSA Coordinator	Review Innovation project process and top ranking projects
Mar 4	DHS-BHD Staff	Review Innovation project process and top ranking projects

The community Innovation application inviting community members and providers to submit innovative project proposals to address mental health challenges in Sonoma County was released on July 19 and had a posted deadline of October 18, essentially giving the community a 60-day period to review and develop an application for Innovation funding. Email notices were sent out to all MHSA Stakeholders, MHSA Steering Committee members, and BHD contractors. In addition,

announcements were made at all stakeholder meetings and flyers distributed to be available in public places. To educate the public on Innovation and MHSA requirements, review the application and evaluation criteria and address any questions from the community five community presentations were held in strategic geographic locations as noted below.

Date/Time	Location
Wednesday, September 4, 2019 10:30a – 12:30pm	Guerneville Regional Library 14107 Armstrong Woods Rd. **Guerneville**
Wednesday, September 4, 2019 2:30 – 5:30pm	Sonoma Valley Regional Library 755 West Napa Street **Sonoma**
Wednesday, September 11, 2019 9 – 11am	DHS Administration 1425 Neotomas Ave. **Santa Rosa**
Wednesday, September 11, 2019 1 – 3pm	Petaluma Health District, 1425 N. McDowell Blvd., Rm 100 **Petaluma**
Friday, September 13, 2019 1 – 3pm	Healdsburg Library 139 Piper St. **Healdsburg**

An Innovation 2020 FAQ was established to note questions and corresponding responses recorded at the community presentations. Furthermore, an email address SonomaInnovation2020@gmail.com was set up for community members to submit questions at their convenience. To promote transparency and equity in information, the FAQ was updated as a living document on the County's website and sent out to all who attended and signed in at a community meeting.
The proposed 30-day Public Review and Comment Period for the DHS-BHD Innovation Proposal in the UC Davis EP LHCN Collaborative is anticipated to take place from Monday, April 27, 2020 – Wednesday, May 27, 2020. MHP staff is holding a public hearing at the May meeting of the Sonoma County Mental Health Board on Wednesday, May 27, 2020 from 5-7 pm in compliance with California Code of Regulations (CCR) 3315(a)(b). During the public review/comment period, the Division's Proposed Innovation Project participation in the UC Davis EP LHCN Collaborative will be posted to community bulletin boards, libraries and emailed to all MHSA stakeholders. It will also be posted to the DHS-BHD's website, and available to all interested parties upon request. All community stakeholders will be invited to participate in the public review/comment process.

Total Budget Request by Fiscal Year:

Total budget by fiscal year for the county collaborative portion of the costs.

	FY 20/21	FY 21/22	FY 22/23	FY 23/24	TOTAL
Total County Contribution to Collaborative	$159,274	$128,747	$132,390	$54,900	$475,311

Budget Narrative for LHCN and Evaluation:

The costs for the LHCN and Evaluation component of the project are described below. Unlike the initial five counties who established the LHCN, the costs for Sonoma county to join the project are not proportional based on the size of their county. Instead, the costs outlined below are based on the

added expenses needed to cover activities for one additional program to join the LHCN. Therefore, the budget narrative is different from the one in the main proposal.

Personnel

The total personnel cost for the county portion of the evaluation and learning health care network component at UC Davis is $118,073 over 4 fiscal years. This includes $81,913 for salaries and $36,160 for benefits. Personnel will include:

- Tara Niendam, Ph.D. The PI of the project with part time effort for the duration of the project.
- Joy Melnikow, M.D., M.PH., co-investigator with an expertise in health care policy, research, and cost effectiveness evaluation with part time effort for the duration of the project.
- Laura Tully, Ph.D., co-investigator with expertise in mobile health platforms and clinical training with part time effort for the duration of the project.
- Valerie Tryon, Ph.D. A project coordinator with part time effort for the duration of the project.
- Andrew Padovani, Ph.D., biostatistician with part time effort for the duration of the project.
- Brooke Herevia, A research administrator with part time effort for duration of the project.
- TBN, One part-time research assistants for years 1-4.

The personnel costs include a 3% annual salary escalation for cost-of-living increases. Fringe benefits are calculated using UC Davis' federally negotiated rate agreement. Rates are applied by title code and fiscal year.

Supplies

The total cost for supplies will be $12,510. This will include project supplies handheld tablet devices for the Sonoma county program, including replacements (8 devices initially, 1 replacement per year over 4 years, $600 per device). Additional supply funds will cover software for project staff, stakeholder meeting costs, mobile hotspot subscription for the site, miscellaneous project supplies (copies, folders, etc.), and translation services.

Travel

Travel costs will total $7,200 over the course of the project. The majority of travel costs are for site visits to the program over 4 years. Travel for consultants is also included for Years 1-4. The remaining travel costs will go toward conference travel for dissemination of results for Years 1-4.

Subcontracts

The project budgets for a subcontract with UCSF to perform the fidelity assessment in Sonoma county. Subcontract costs will total $14,572.

Consultation

The budget includes costs of multiple consultants. The first is Don Addington, M.D. from University of Calgary. He will provide expertise on fidelity assessment. The second consultant is Sonya Gabrielian, M.D. from UCLA. She will provide consultation on risk factors for homelessness. We will add additional funds Quorum Technologies for application development and support in Years 1-4. These costs to Quorum Technologies will include consultation to provide guidance in the development of the app's user interface to improve the consumer and provider experience with the app and will total $50,000 over the duration of the project.

Other Costs

Other costs will include subject and staff payments for taking surveys and participating in focus groups. We will pay clients and staff in Sonoma during Years 1-4. We have budgeted $500 per year

for clients and $500 per year for staff. We will also include $550 in funds to contribute to costs for the annual executive meeting and site visits for Years 1-4.

Indirect Costs
Indirect costs are calculated at the MHSOAC's published rate of 15% of Total Cost, totaling $34,559.

Total Cost
The total cost for the LHCN and Evaluation Budget from County INN funding will be $244,964.

Budget by Fiscal Year and Specific Budget Category for LHCN and Evaluation

BUDGET CONTEXT - EXPENDITURES BY FUNDING SOURCE AND FISCAL YEAR (FY)						
EXPENDITURES						
		7/1/20-6/30/21	**7/1/21-6/30/22**	**7/1/22-6/30/23**	**7/1/23-6/30/24**	**1/1/19-12/31/23**
PERSONNEL COSTS (salaries, wages, benefits)		**FY 20/21 (12 mo)**	**FY 21/22 (12 mo)**	**FY 22/23 (12 mo)**	**FY 23/24 (12 mo)**	**TOTAL**
1.	Salaries	$19,580	$20,167	$20,771	$21,395	$81,913
2.	Benefits	$8,256	$8,757	$9,292	$9,855	$36,160
3.	Indirect Costs	$4,912.24	$5,104.24	$5,305.24	$5,514.71	$20,836
4.	Total Personnel Costs	$32,748	$34,028	$35,368	$36,765	$138,909
OPERATING COSTS		**FY 20/21 (12 mo)**	**FY 21/22 (12 mo)**	**FY 22/23 (12 mo)**	**FY 23/24 (6 mo)**	**TOTAL**
5.	Direct Costs					
6.	Indirect Costs					
7.	Total Operating Costs					
NONRECURRING COSTS (equipment, technology)		**FY 20/21 (12 mo)**	**FY 21/22 (12 mo)**	**FY 22/23 (12 mo)**	**FY 23/24 (6 mo)**	**TOTAL**
8a.	Direct Costs (Supplies)	$7,890	$1,490	$1,490	$1,640	$12,510
8b.	Direct Costs (Travel)	$1,800	$1,800	$1,800	$1,800	$7,200
8c.	Direct Costs (Other Directs)	$1,250	$1,100	$1,100	$1,100	$4,550
9.	Indirect Costs	$1,930.59	$774.71	$774.71	$801.18	$4,281
10.	Total Operating Costs	$12,871	$5,165	$5,165	$5,341	$28,541
CONSULTANT COSTS/ CONTRACTS (clinical training, facilitator, evaluation)		**FY 20/21 (12 mo)**	**FY 21/22 (12 mo)**	**FY 22/23 (12 mo)**	**FY 23/24 (6 mo)**	**TOTAL**
11a.	Direct Costs (Subawards)	$14,572	$0	$0	$0	$14,572
11b.	Direct Costs (Consultants & App)	$20,875	$10,875	$10,875	$10,875	$53,500
12.	Indirect Costs	$3,683.82	$1,919.12	$1,919.12	$1,919.12	$9,441
13.	Total Consultant Costs	$39,131	$12,794	$12,794	$12,794	$77,513
OTHER EXPENDITURES (please explain in budget narrative)		**FY 20/21 (12 mo)**	**FY 21/22 (12 mo)**	**FY 22/23 (12 mo)**	**FY 23/24 (6 mo)**	**TOTAL**
14.						
15.	Total Other Expenditures					
BUDGET TOTALS:						
Personnel (salaries and benefits)		$27,836	$28,924	$30,063	$31,250	$118,073
Direct Costs (consultation, nonrecurring costs)		$46,387	$15,265	$15,265	$15,415	$92,332
Indirect Costs (15% TC)		$10,527	$7,798	$7,999	$8,235	$34,559
TOTAL INNOVATION BUDGET		**$84,750**	**$51,987**	**$53,327**	**$54,900**	**$244,964**

Budget Narrative for County Specific Needs:

Buckelew as the lead agency will leverage the One Mind grant funding and the Sonoma County Innovations funding to open and operate the Elizabeth Morgan Brown One Mind ASPIRe clinic. We will utilize a portion of the innovation funding- $230K to augment the staffing of the clinic to support implementation of this project. The last year of the budget 23/24 is blank as there are only enough funds available to support the first three years. The intent of partners is to continue to seek additional funding via philanthropic, foundation and statewide grants to augment the 23/24 budget.

Budget by Fiscal Year and Specific Budget Category for County Specific Needs

PERSONNEL COSTS (salaries, wages, benefits)		**FY 20/21**	**FY 21/22**	**FY 22/23**	**FY 23/24**	**TOTAL**
1.	Salaries	67,750	69,783	71,876		209,409
2.	Direct Costs					
3.	Indirect Costs	6,774	6,977	7,187		20,938
4.	Total Personnel Costs	74,524	76,760	79,063		**230,347**
OPERATING COSTS		**FY 20/21**	**FY 21/22**	**FY 22/23**	**FY 23/24**	**TOTAL**
5.	Direct Costs					
6.	Indirect Costs					
7.	Total Operating Costs					
NONRECURRING COSTS (equipment, technology)		**FY 20/21**	**FY 21/22**	**FY 22/23**	**FY 23/24**	**TOTAL**
8.						
9.	Total Non-recurring Costs					
CONSULTANT COSTS/ CONTRACTS (clinical training, facilitator, evaluation)		**FY 20/21**	**FY 21/22**	**FY 22/23**	**FY 23/24**	**TOTAL**
10.	Direct Costs					
11.	Indirect Costs					
12.	Total Consultant Costs					
OTHER EXPENDITURES (please explain in budget narrative)		**FY 20/21**	**FY 21/22**	**FY 22/23**	**FY 23/24**	**TOTAL**
13.						
14.	Total Other Expenditures					
Personnel (line 1)		67,750	69,783	71,876		209,409
Direct Costs (add lines 2, 5 and 11 from above)						
Indirect Costs (add lines 3, 6 and 12 from above)		6,774	6,977	7,187		20,940
Non-Recurring costs (line 10)						
Other expenditures (line 16)						
TOTAL INNOVATION BUDGET		74,524	76,760	79,063		**230,347**

Budget Narrative for Total Budget Context- Expenditures by Funding Source and Fiscal Year:

Buckelew Programs was awarded a grant from the One Mind Foundation to support the development of an Early Psychosis Intervention program in Sonoma County. Buckelew is the lead agency in this award and has chosen to partner with two other community-based organizations- Aldea and On the Move Bay Area- to deliver the Coordinated Specialty Care Model to Sonoma County residents. The grant total is $1.35 million dollars from December 2019 and ends on July 31st, 2022. This grant will be utilized to open and operate the Elizabeth Morgan Brown One Mind ASPIRe program in Santa Rosa. As part of this initiative, Buckelew as the lead agency is applying for partnership in the Early Psychosis Learning Health Care Network Statewide Collaborative and utilizing MHSA Innovation funding to support this partnership. We will utilize the $230,347 to augment the CSC clinic as the costs to operate exceed the One Mind grant. By blending the Innovation funding and One Mind grant, we plan to continue to operate this program with additional philanthropic support in conjunction with EPI-Cal funding.

Total Budget Context- Expenditures by Funding Source and Fiscal Year:

A.	**Estimated total mental health expenditures for ADMINISTRATION for the entire duration of this INN Project by FY & the following funding sources:**	**FY 20/21**	**FY 21/22**	**FY 22/23**	**FY 23/24**	**TOTAL**
1.	Innovative MHSA Funds	$74,524	$76,760	$79,063		4230,347
2.	Federal Financial Participation					
3.	1991 Realignment					
4.	Behavioral Health Subaccount					
5.	Other Funding					
6.	**Total Proposed Administration**	$74,524	$76,760	$79,063		$230,347
B.	**Estimated total mental health expenditures for EVALUATION for the entire duration of this INN Project by FY & the following funding sources:**	**FY 20/21**	**FY 21/22**	**FY 22/23**	**FY 23/24**	**TOTAL**
1.	Innovative MHSA Funds	$84,750	$51,987	$53,327	$54,900	$244,964
2.	Federal Financial Participation					
3.	1991 Realignment					
4.	Behavioral Health Subaccount					
5.	Other Funding					
6.	**Total Proposed Evaluation**	**$84,750**	**$51,987**	**$53,327**	**$54,900**	**$244,964**
C.	**Estimated TOTAL mental health expenditures for the entire duration of this INN Project by FY & the following funding sources:**	**FY 20/21**	**FY 21/22**	**FY 22/23**	**FY 23/24**	**TOTAL**
1.	Innovative MHSA Funds	$159,274	$128,747	$132,390	$54,900	$475,311
2.	Federal Financial Participation					
3.	1991 Realignment					
4.	Behavioral Health Subaccount					
5.	Other Funding					
6.	**Total Proposed Expenditures**	$159,274	$128,747	$132,390	$54,900	$475,311

Appendix VII: Stanislaus County

County Contact and Specific Dates

- Primary County Contacts (Name, Email, Phone):
  - Martha Cisneros Campos, mcisneros@stanbhrs.org, 209-525-5324
  - Kirsten Jasek-Rysdahl, KJasek-Rysdahl@stanbhrs.org, 209-525-6085
- Proposed dates for local 30-day Public Review and Comment Period:
  - April 21, 2021 – May 21, 2021
- Proposed date for posting for local MH Board hearing:
  - May 27, 2021
- Proposed date to send to MHSOAC
  - June 1, 2021
- Proposed date of BOS review and approval:
  - June 15, 2021

Description of the Local Need

The incidence of schizophrenia in the world population is approximately 1% with an estimated 75% of those individuals having experienced a prodromal or clinically high-risk period before converting to schizophrenia. It is estimated that anywhere from 20-40% of individuals classified as clinically high risk will convert to schizophrenia without treatment interventions. Few studies have been done on the prevalence of prodromal or clinically high-risk states. One study found that 8% of adolescents were able to be classified as clinically high risk utilizing the evidence-based Structured Interview for Psychosis-Risk Syndromes (SIPS) screener (Kelleher et al, 2012).

Stanislaus County has an approximate population of 550,000, which equates to an estimated 5,500 people experiencing schizophrenia within the county. Considering estimates of the cost to a community for a person with schizophrenia throughout their lifetime is up to $1,000,000, this equates to around $5 billion dollars at current population numbers. In addition, Stanislaus County has an approximate adolescent population of 35,000. At current estimates, anywhere from 560-1,120 of these adolescents may convert to schizophrenia without treatment interventions.

Stanislaus County currently has an early psychosis intervention program, LIFE Path, serving ages 14-25 and their families who have either qualified as clinically high risk (prodromal) or have experienced a first break within the past year. The program is modeled after the EASA (Early Assessment Support Alliance) program of the state of Oregon, an evidenced-based Coordinated Specialty Care (CSC) program. LIFE Path utilizes evidence-based practices such as Multi-Family Group, Cognitive Behavioral Therapy for Psychosis, and Individualized Resiliency Treatment. The LIFE Path program is designed to provide intensive therapeutic services, family psychoeducation, educational/vocational support, case management, and optional medication services. In addition, the LIFE Path program includes a Parent Advocate to assist family members in negotiating educational and mental health systems.

Although operating since 2011, LIFE Path has predominantly operated independently in the early psychosis field outside its mentorship with EASA due to the limited first episode psychosis (FEP) programs at the time, variance between FEP programs, and lack of a shared network for FEP programs. LIFE Path has provided early psychosis services to 162 unduplicated clients and additional family members since its inception but has struggled in attempting to adapt the various measurement tools utilized by the County that gauge a program's growth and efficacy. This has been due to the lack of tools designed and developed specifically for CSC/FEP programs.

Over the last few years, with various legislation and funding streams opened for FEP programs, there has been a dramatic increase in program availability across the nation and throughout California. There has also been an increase in the availability of learning collectives regarding FEP. As the nation and California build capacity and knowledge in the area of early psychosis, Stanislaus County and the LIFE Path program can benefit from those strides through the Early Psychosis Learning Health Care Network (LHCN). Stanislaus County, through LIFE Path, and its participants strive to learn more, apply the knowledge gained, and improve our ability to positively impact clients experiencing early psychosis.

Description of the Response to the Local Need

The LHCN Project aligns with the current challenges of the LIFE Path program and will improve the program's ability to:

- Increase fidelity to current evidenced-based practices including effective and efficient service delivery
- Improve data collection, tracking, analysis, and reporting
- Provide participants, counselors, and administrators access to data in real-time
- Engage participants and family members in treatment and recovery

As part of the Early Psychosis Learning Health care Network Collaborative, Stanislaus County and LIFE Path will benefit from sharing and learning with the multiple and diverse participating counties. LIFE Path will gain technical assistance; an effective early psychosis-specific data collection methodology; innovative treatment approaches; and a learning collaborative that will enhance the program's access to new research, clinical support, and solution-oriented ideas for programmatic challenges. By receiving this assistance and support, LIFE Path will be able to use the evidence-based practices to be more effective and efficient and will also improve engagement of participants and family members in treatment and recovery. The expectation is that LIFE Path will increase the number of referred individuals who move forward with the assessment process as well as those who are retained in treatment and recovery. LIFE Path anticipates an increase of 20% in the number of clients served by the end of the Innovation Project. It is important to note that LIFE Path has identified that their existing internal resources and capacity is sufficient to improve and expand their services to support this Project with the additional support of BHRS and the Program Assistant identified in this Proposal.

Cultural & Linguistic Competency

Based on the Department of Finance January 2020 population estimates, Stanislaus County has 557,709 residents, of which 45.6% reported Hispanic/Latino; 42.6% reported White; 5.3% reported Asian; 2.6% reported Black; 2.5% reported Two or more races (not Hispanic/Latino); .7% Native Hawaiian or Pacific Islander; .5% reported American Indian and Alaska Native; and .2% reported Other Race (not Hispanic/Latino).

Although diverse, Stanislaus County currently has one threshold language of Spanish. BHRS county staff consist of approximately 25% Spanish speaking staff. In addition, we have staff that speak other languages such as; Cambodian, Assyrian, Hindi, and many other languages. The LIFE Path program maintains a Spanish bilingual case manager and Spanish bilingual clinician. In addition, LIFE Path is a collaborative program between Sierra Vista Child & Family Services and Center for Human Services and is able to use the various language services of the two organizations. Sierra Vista Child & Family Services employs staff fluent in several languages including Cambodian, Laotian, Farsi and Punjabi. Both Sierra Vista Child & Family Services and Center for Human Services have numerous

interpreters on contract if needed and Sierra Vista Child & Family Services also maintains a contract with a language line service if an interpreter is not available.

BHRS is committed to strategies that embrace diversity and to provide welcoming behavioral health and compassionate recovery services that are effective, equitable, and responsive to individuals' cultural health beliefs and practices. To ensure we continue to improve the quality of services and eliminate inequities and barriers to care for marginalized cultural and ethnic communities, BHRS supports the Cultural Competence, Equity, and Social Justice Committee (CCESJC). The committee consists of program providers, consumers, family members, and communities representing all cultures and meets monthly to discuss cultural and linguistic needs of our county. Our Cultural Competence and Ethnic Services Manager chairs the committee and ensures the county behavioral health systems are culturally and linguistically competent and responsive in the delivery of behavioral health services. This innovation project will support the cultural and linguistic needs of the county through a better understanding of the client needs.

Description of the Local Community Planning Process

Stanislaus County Behavioral Health and Recovery Services (BHRS) had been actively engaging in the Community Planning Process specifically with the intent to inform engaged stakeholders on updates facing MHSA, with the focus of strengthening stakeholder engagement. Traditionally stakeholder meetings were convened twice a year, in some years quarterly. However, with the onset of the Covid-19 crisis that began in March of 2020 and policy effects on MHSA, BHRS identified the opportunity to create a more robust stakeholder process. In this effort stakeholders were informed formally of MHSA regulations and their specific role as it relates to the community planning process for the three-year plan and annual update.

Formal Representative Stakeholder Steering Committee (RSSC) meetings for MHSA were held on June 12th, June 26th, September 18th, and December 11th of 2020. Each meeting averaged 62-80 participants; the information session had 44 attendees. The meeting held on December 11, 2020 was also offered in person at the new Granger Community Center to gain additional participation from peers and consumers. During the December 11th meeting RSSC members were informed of the reversion issue facing BHRS; related to unspent innovation funds from previous fiscal periods. Stanislaus and other counties facing this issue, were encouraged by the MHSOAC to explore alignment with innovation projects already approved. BHRS quickly observed that two multicounty collaborative innovation projects provided by the MHSOAC aligned very well with insights from stakeholder input on the BHRS system as whole and one aligned well with BHRS efforts to create a more robust stakeholder process for future innovations.

To explore this further and to ensure stakeholder support on these innovation projects, BHRS conducted an information session that detailed each project proposed as well as allowed time for discussion and questions surrounding these projects. The information session for proposed innovations was a dedicated meeting for proposed innovations on December 29th. Following the December 29th innovation information session stakeholders were invited to the RSSC meeting on January 15, 2021 to formally measure the level of support to move forward and pursue the proposed innovation projects. After engaging in small group discussion and large group feedback discussion, RSSC members were surveyed utilizing the gradients of agreement scale; a scale utilized to measure the level of agreement and support towards a proposal. BHRS provided a one through five scale, with one being non acceptance of the proposed project and five being complete and full acceptance. RSSC members identified fours and fives as their measurement during this meeting. The meeting concluded with agreement to move forward with all three proposed innovations.

Proposed projects will go formally to the Stanislaus County Board of Supervisors (BOS) on June 15, 2021. Following formal approval by the BOS the projects will go through the review period with the MHSOAC as well be posted for the 30-Day local review period for the public.

Total Budget Request by Fiscal Year:

Total budget by fiscal year for the county collaborative portion of the costs.

	FY 21/22	FY 22/23	FY 23/24	FY 24/25	FY 25/26	TOTAL
Total County Contribution to Collaborative	*340,777*	*318,091*	*327,881*	*338,765*	*239,119*	*1,564,633*

Budget Narrative for LHCN and Evaluation:

The costs for the LHCN and Evaluation component of the project are described below. Unlike the initial five counties who established the LHCN, the costs for Stanislaus county to join the project are not proportional based on the size of their county. Instead, the costs outlined below are based on the added expenses needed to cover activities for one additional program to join the LHCN. Therefore, the budget narrative is different from the one in the main proposal.

Personnel

The total personnel cost for the county portion of the evaluation and learning health care network component at UC Davis is $112,016 over 4 fiscal years. This includes $77,295 for salaries and $34,721 for benefits. Personnel will include:

- Tara Niendam, Ph.D. The PI of the project with part time effort for the duration of the project.
- Joy Melnikow, M.D., M.PH., co-investigator with an expertise in health care policy, research, and cost effectiveness evaluation with part time effort for the duration of the project.
- Laura Tully, Ph.D., co-investigator with expertise in mobile health platforms and clinical training with part time effort for the duration of the project.
- Valerie Tryon, Ph.D. A project coordinator with part time effort for the duration of the project.
- Andrew Padovani, Ph.D., biostatistician with part time effort for the duration of the project.
- Brooke Herevia, A research administrator with part time effort for duration of the project.
- TBN, One part-time research assistants for years 1-4.

The personnel costs include a 3% annual salary escalation for cost-of-living increases. Fringe benefits are calculated using UC Davis' federally negotiated rate agreement. Rates are applied by title code and fiscal year.

Supplies

The total cost for supplies will be $11,210. This will include project supplies handheld tablet devices for the Stanislaus County LIFE Path program, including replacements (8 devices initially, 1 replacement per year over 4 years, $600 per device). Additional supply funds will cover software for project staff, stakeholder meeting costs, mobile hotspot subscription for the site, miscellaneous project supplies (copies, folders, etc.), and translation services.

Travel

Travel costs will total $6,600 over the course of the project. The majority of travel costs are for site visits to the program over 4 years. Travel for consultants is also included for Years 1-4. The remaining travel costs will go toward conference travel for dissemination of results for Years 1-4.

Subcontracts

The project budgets for a subcontract with UCSF to perform the fidelity assessment, focus groups, and qualitative interviews, and county-level cost and utilization analysis in Stanislaus county.

Subcontract costs will total $207,312. Their total cost is broken down into costs for personnel salaries, fringe benefits, travel, and supplies. Personnel include two co-investigators (Rachel Loewy, Ph.D. and Mark Savill, Ph.D.), a project manager, and a part-time clinical research coordinator.

Consultation
The budget includes costs of multiple consultants. The first is Don Addington, M.D. from University of Calgary. He will provide expertise on fidelity assessment. The second consultant is Sonya Gabrielian, M.D. from UCLA. She will provide consultation on risk factors for homelessness. We will add additional funds Quorum Technologies for application development and support in Years 1-4. These costs to Quorum Technologies will include consultation to provide guidance in the development of the app's user interface to improve the consumer and provider experience with the app and will total $50,000 over the duration of the project.

Other Costs
Other costs will include subject and staff payments for taking surveys and participating in focus groups. We will pay clients and staff in Stanislaus during Years 2-3. We have budgeted $125 per year for clients and $125 per year for staff. We will also include $400 in funds to contribute to costs for the annual executive meeting and site visits for Years 1-4.

Indirect Costs
Indirect costs are calculated at the MHSOAC's published rate of 15% of Total Cost, totaling $32,510.

Total Cost
The total cost for the LHCN and Evaluation Budget from County INN funding will be $424,048.

Budget by Fiscal Year and Specific Budget Category for County Specific Needs

BUDGET BY FISCAL YEAR AND SPECIFIC BUDGET CATEGORY FOR LHCN AND EVALUATION							
EXPENDITURES							
PERSONNEL COSTS (salaries, wages, benefits)		**FY 21/22**	**FY 22/23**	**FY 23/24**	**FY 24/25**	**FY 25/26**	**TOTAL**
1.	Salaries	18,477	19,030	19,600	20,188		77,295
2.	Direct Costs	7,928	8,409	8,922	9,462		34,721
3.	Indirect Costs	4,660	4,842	5,033	5,232		19,767
4.	Total Personnel Costs	31,065	32,281	33,555	34,882		131,783
OPERATING COSTS		**FY 21/22**	**FY 22/23**	**FY 23/24**	**FY 24/25**	**FY 25/26**	**TOTAL**
5a.	Direct Costs (Supplies)	7,490	1,190	1,190	1,340		11,210
5b.	Direct Costs (Travel)	1,650	1,650	1,650	1,650		6,600
5c.	Direct Costs (Other Directs)	100	350	350	100		900
6.	Indirect Costs	1,631	563	563	545		3,302
7.	Total Operating Costs	10,871	3,753	3,753	3,635		22,012
NONRECURRING COSTS (equipment, technology)		**FY 21/22**	**FY 22/23**	**FY 23/24**	**FY 24/25**	**FY 25/26**	**TOTAL**

8							
9.							
10.	Total Non-recurring Costs						
CONSULTANT COSTS/ CONTRACTS (clinical training, facilitator, evaluation)		**FY 21/22**	**FY 22/23**	**FY 23/24**	**FY 24/25**	**FY 25/26**	**TOTAL**
11a.	Direct Costs (Subawards)	50,244	49,914	52,034	55,120		207,312
11b.	Direct Costs (Consultants & App)	20,875	10,875	10,875	10,875		53,500
12.	Indirect Costs	3,684	1,919	1,919	1,919		9,441
13.	Total Consultant Costs	74,803	62,708	64,828	67,914		270,253
OTHER EXPENDITURES (please explain in budget narrative)		**FY 21/22**	**FY 22/23**	**FY 23/24**	**FY 24/25**	**FY 25/26**	**TOTAL**
14.							
15.							
16.	Total Other Expenditures						
BUDGET TOTALS:							
Personnel (line 1)		26,405	27,439	28,522	29,650		112,016
Direct Costs (add lines 2, 5 and 11 from above)		80,359	63,979	66,099	69,085		279,522
Indirect Costs (add lines 3, 6 and 12 from above)		9,974	7,324	7,515	7,697		32,510
Non-Recurring costs (line 10)							
Other expenditures (line 16)							
TOTAL INNOVATION BUDGET		**116,738**	**98,742**	**102,136**	**106,432**		**424,048**

Budget Narrative for County Specific Needs:

Personnel

The total personnel cost for the county portion is $822,374 over five years. This includes $490,573 for salaries and $311,801 for fringe benefits.

Personnel will include a 0.5 FTE Software Developer/Analyst III and a 0.5 FTE Staff Services Coordinator for five years. After reviewing the overall goals and objectives for all participating counties we consulted with UC Davis to assess our internal capacity with what is required to support this project successfully. UC Davis consulted with the current participating counties to develop a recommendation with what the ideal internal support structure or team would consist of. The current participating counties shared lessons learned and stated where they may have underestimated the internal staffing need in addition to the workflow needed from the internal staff to carry the project goals throughout the various stages. BHRS and LIFE Path will be working together to expand data collection, analysis, and sharing/reporting that is detailed in the proposal above. The .5 FTE positions are designed to support this expansion and learning, as well as the coordination of these efforts. The positions are not exclusive to an administrative and oversight role but are designed to support and

coordinate the project based on the recommendations from UC Davis and the current participating counties, and to meet resource capacity need for the program and project to be successful. It should also be noted that with these County support positions along with the Program Assistant described below, the program structure and resources will meet the capacity requirements as specified in the description of responsibilities for this project.

Staff Services Coordinator will:

- Oversee and act as liaison to the Innovation Project contractors
- Coordinate and facilitate meetings and discussions amongst Innovation Project contractors, partners, and other stakeholders
- Coordinate internal staff and project partners to ensure the necessary assignments are completed to meet project requirements, timelines, and quality expectations
- Develop and monitor project timelines; provide updates/status of projects to stakeholders as appropriate
- Oversee, coordinate, and provide technical assistance for the data collection, analysis and reporting of the performance measures for this Innovation Project
- Provide training and technical assistance related to project data and results to staff and stakeholders

Software Developer/Analyst III will:

- Help identify the appropriate county-level data and data transfer methods
- Extract county-level data from the electronic health record and other program databases and sources; de-identify data before transferring to contracted staff
- Identify problems and possible solutions in the county-level and program-level data (e.g., issues with available data or methods)
- Participate in all relevant meetings regarding data for this Innovation Project

The personnel costs include a 3% annual increase to include cost-of-living salary increases and the associated retirement, and FICA increases based on the increased salaries as well as increases for health care costs.

Operating Costs

The ongoing operating costs total $30,700 over five years. This includes cell phones, office supplies, copier costs, computer licenses, MiFi service for laptops, utilities, alarm and security costs, zoom subscriptions, telephone and data processing services, and janitorial costs.

Nonrecurring Costs

Nonrecurring costs total $10,900 for equipment for the set-up of the office for the two staff members. This includes, desks, chairs, computers, laptops, and software.

Contracts

Contracts total $276,611 over five years to provide program assistance to the LIFE Path contractor for coordination and facilitation between the contractor, clients and family members, UC Davis, and BHRS. Assistance will also be provided for data collection and scheduling. A 3% annual increase is included to support cost of living increases.

The Program Assistant will:

- Instruct and support clients and family members in the use of technology for data collection
- Educate new clients and families on Innovations project and gather consents for projects

- Monitor timeliness of data collection from clients and family members
- Scheduling client and families to complete core battery on tablet at each follow up
- Assist in coordination with UCD and BHRS

Budget by Fiscal Year and Specific Budget Category for County Specific Needs

BUDGET BY FISCAL YEAR AND SPECIFIC BUDGET CATEGORY FOR COUNTY SPECIFIC NEEDS							
EXPENDITURES							
PERSONNEL COSTS (salaries, wages, benefits)		**FY 21/22**	**FY 22/23**	**FY 23/24**	**FY 24/25**	**FY 25/26**	**TOTAL**
1.	Salaries	154,898	159,545	164,331	169,261	174,339	822,374
2.	Direct Costs						
3.	Indirect Costs						
4.	Total Personnel Costs	154,898	159,545	164,331	169,261	174,339	822,374
OPERATING COSTS		**FY 21/22**	**FY 22/23**	**FY 23/24**	**FY 24/25**	**FY 25/26**	**TOTAL**
5.	Direct Costs	6,140	6,140	6,140	6,140	6,140	30,700
6.	Indirect Costs						
7.	Total Operating Costs	6,140	6,140	6,140	6,140	6,140	30,700
NONRECURRING COSTS (equipment, technology)		**FY 21/22**	**FY 22/23**	**FY 23/24**	**FY 24/25**	**FY 25/26**	**TOTAL**
8	Desk, Chair, Computer, Laptop	9,900					9,900
9.	Software	1,000					1,000
10.	Total Non-recurring Costs	10,900					10,900
CONSULTANT COSTS/ CONTRACTS (clinical training, facilitator, evaluation)		**FY 21/22**	**FY 22/23**	**FY 23/24**	**FY 24/25**	**FY 25/26**	**TOTAL**
11a.	Direct Costs	52,101	53,664	55,274	56,932	58,640	276,611
12.	Indirect Costs						
13.	Total Consultant Costs	52,101	53,664	55,274	56,932	58,640	276,611
OTHER EXPENDITURES (please explain in budget narrative)		**FY 21/22**	**FY 22/23**	**FY 23/24**	**FY 24/25**	**FY 25/26**	**TOTAL**
14.							
15.							
16.	Total Other Expenditures						
BUDGET TOTALS:							
Personnel (line 1)		154,898	159,545	164,331	169,261	174,339	822,374

Direct Costs (add lines 2, 5 and 11 from above)	6,140	6,140	6,140	6,140	6,140	30,700
Indirect Costs (add lines 3, 6 and 12 from above)						
Non-Recurring costs (line 10)	10,900					10,900
Other expenditures (line 16)						
TOTAL INNOVATION BUDGET	224,039	219,349	225,745	232,333	239,119	1,140,585

Budget Narrative for Total Budget Context- Expenditures by Funding Source and Fiscal Year: Funding for the project will come from MHSA Innovation funds.

Total Budget Context- Expenditures by Funding Source and Fiscal Year:

TOTAL BUDGET CONTEXT- EXPENDITURES BY FUNDING SOURCE AND FISCAL YEAR (FY)							
ADMINISTRATION:							
A.	**Estimated total mental health expenditures for ADMINISTRATION for the entire duration of this INN Project by FY & the following funding sources:**	**FY 21/22**	**FY 22/23**	**FY 23/24**	**FY 24/25**	**FY 25/26**	**TOTAL**
1.	Innovative MHSA Funds	224,039	219,349	225,745	232,333	239,119	1,140,585
2.	Federal Financial Participation						
3.	1991 Realignment						
4.	Behavioral Health Subaccount						
5.	Other Funding						
6.	**Total Proposed Administration**	**224,039**	**219,349**	**225,745**	**232,333**	**239,119**	**1,140,585**
EVALUATION:							
B.	**Estimated total mental health expenditures for EVALUATION for the entire duration of this INN Project by FY & the following funding sources:**	**FY 21/22**	**FY 22/23**	**FY 23/24**	**FY 24/25**	**FY 25/26**	**TOTAL**
1.	Innovative MHSA Funds	116,738	98,742	102,136	106,432		424,048
2.	Federal Financial Participation						
3.	1991 Realignment						
4.	Behavioral Health Subaccount						
5.	Other Funding						
6.	**Total Proposed Evaluation**	**116,738**	**98,742**	**102,136**	**106,432**		**424,048**
TOTAL:							

C.	Estimated TOTAL mental health expenditures (this sum to total for funding requested) for the entire duration of this INN Project by FY & the following funding sources:	FY 21/22	FY 22/23	FY 23/24	FY 24/25	FY 25/26	TOTAL
1.	Innovative MHSA Funds	340,777	318,091	327,881	338,765	239,119	1,564,633
2.	Federal Financial Participation						
3.	1991 Realignment						
4.	Behavioral Health Subaccount						
5.	Other Funding						
6.	**Total Proposed Expenditures**	**340,777**	**318,091**	**327,881**	**338,765**	**239,119**	**1,564,633**

Appendix VIII: Kern County

County Contact and Specific Dates

- Primary County Contacts (Name, Email, Phone):
  - Christina Rajlal, PhD, MBA, Crajlal@kernbhrs.org, (661) 868-6681
- Date Proposal posted for 30-day Public Review:
  - December 6, 2021-January 6, 2022
- Date of Local Behavioral Health Board hearing:
  - Behavioral Health Board Presentation and approval: January 24, 2022
- Date of Board of Supervisors approval and calendared date to appear: February 8, 2022

Description of Local Need

Kern County needs a robust model that knits together the existing services that are provided to people experiencing early psychosis (EP). Through the Mental Health Services Act (MHSA) and additional programming throughout the Behavioral Health System of Care, Kern County provides stand-alone programs that support people experiencing psychosis and early psychosis symptoms; however, Kern County's current system to support this underserved population is fragmented within the System of Care. Kern County needs an approach to serving those with some of the highest levels of need through a well vetted program like a Coordinated Specialty Care (CSC) team. Through applying for the Early Psychosis Intervention Plus (EPI-Plus) grant, Kern County did an analysis of the current system of care in supporting those experiencing EP. Through this analysis the following need and suggested improvements were identified:

- To implement a multidisciplinary team to deliver a range of specific services including qualified professional to provide both case management and specific service elements including: nursing services, evidence based psychotherapy, addictions services, supported employment, family education and support, social and community living skills, and case management
- Create explicit admission criteria (e.g. diagnoses served, DUP, age range) with standard screening procedures
- To improve timely contact within 2 weeks of referrals from 60-79% of patients
- To improve assistance with antipsychotic medication within dosing recommendations, with access to IM injections and Clozapine from <1% patients on Clozapine at 2 years
- To improve treatment for substance use disorders (SUD) in providing either Motivational Enhancement (ME) or Cognitive Behavioral Therapy (CBT) from 40-59% with SUD receiving at least three session of either ME or CBT
- To improve Supported Employment programming using Individual Placement and Supports (IPS) and supported education services provided by dedicated staff who are part of the CSC team
- Increase EP specific targeted outreach to community groups from 1-4 community outreach events within a calendar year
- Decrease caseload from 21-30 patients to case manager to 20 patients or less
- Assign Prescriber/ Psychiatrist to CSC team and decrease caseload from 51+ patients to <29 patients per .2 FTE with supervision as appropriate
- Enhance EP programming length of treatment from 1 year or less to up to 4 years (if needed) with appropriate discharge planning and linkage
- Enhance inclusion of peers in program level decision-making, providing direct services (individual and group), and sharing lived experience across all levels of the program, currently target met for 20-39% of patients

Description of the Response to the Local Need

In the last two years, Kern Behavioral Health and Recovery Services (KBHRS) applied for and was granted funding through the MHSOAC for Early Psychosis Intervention Plus Programming. These grant funds will be used to assist Kern County in creating a CSC program treating those experiencing Early Psychosis. All the items bulleted within the section of Description of Local Need, are targets for improvement under the EPI-Plus grant funding. Additionally, to run the CSC Early Psychosis program to fidelity, there are still additional remaining needs including:

- Outcome measurements tracking
- Additional Staffing needs
- Collaboration and network building with leaders and innovators in the field of Early Psychosis

Outcome measurements tracking, offsetting the cost of additional staffing needed to run the EP CSC model to fidelity, and building a collaborative network of leaders and innovators in the field can all be accomplished by requesting to participate in the Learning Healthcare Network Innovation Plan.
This project, led by UC Davis, Behavioral Health Center of Excellence in partnership with universities and multiple other counties, will give Kern County the opportunity to share and discuss outcome measurements with clients in a more effective manner, allow programs to learn/ share through training, and position the state to participate in the development of a nation network to inform and improve care for individuals with early psychosis throughout North America.

Cultural & Linguistic Competency

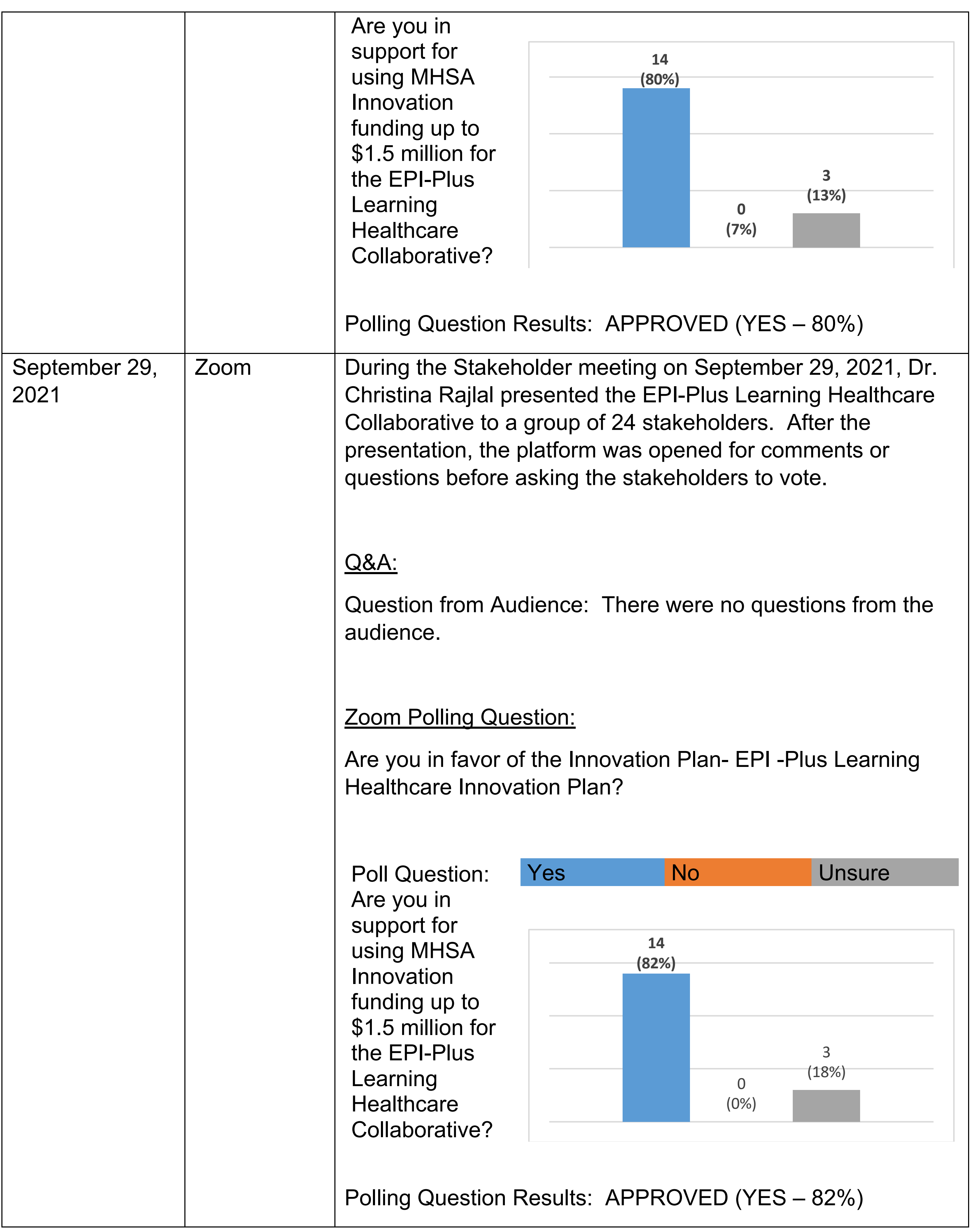
KernBHRS considers cultural competence as a priority for all staff and the department. The benefit from annual training is evident through the care our clients receive. All staff assigned to this Innovation Project will be up to date on their required hours of cultural competence training. They will also be offered additional culturally significant training as per populations that they start to encounter upon launch of the CSC model.
Additionally, the MHSA coordinator and representatives from the MHSA Team sit on the monthly Cultural Competence Resource Committee (CCRC). The CCRC can be leveraged as a resource in the implementation of the Innovation program. In the implementation of the Innovation program and the reporting of the project evaluation, if an issue arises regarding a cultural competence challenge or counsel is needed, this item can be brought to the CCRC for a formal review and recommendation. For instance, if a culturally significant group seems difficult to provide outreach to, this challenge may be presented to the CCRC with requested review and recommendations of how to improve outreach or use specific culturally significant outreach strategies.
The outreach worker for this Innovation plan will be bi-lingual to assist in outreach with Kern County's threshold language of Spanish. The bilingual outreach worker will specifically focus efforts on penetrating hard to reach communities including culturally specific and significant communities within Kern County. Some of these communities that KernBHRS has identified are LatinX including Indigenous populations, Punjabi and East Indian, Asian and Pacific Islander, African American or Black, LGBTQ+, American Indian/ Alaskan Native, school aged youth, foster care, and those involved in the justice system. The outreach worker will have time dedicated to participating in events in partnership with the local community to bring awareness to EP, screening, assessments, and treatment. Some forums that the outreach worker can target will be school presentations, fairs or forums with high-risk individuals, NAMI, and KernBHRS Consumer and Family Learning Center.
Some of the duties of the outreach worker will include outreach to 51 high schools in Kern County, outreach to eight local colleges including Bakersfield College and Cal State Bakersfield, working with the Juvenile Justice System for release of those experiencing EP, young people exiting out of the Lerdo jail at high-risk, training for staff/ contract providers/ community members, culturally specific outreach to LatinX families/ social workers, and increased psychoeducation for clients/ family members/ circle of supports.

Description of the Local Community Planning Process

KernBHRS' Stakeholders will have repeated access to voice their opinions in scheduled stakeholder meetings. Each meeting is publicly announced on the department website, through an email list serve or previous stakeholder's meetings, and social media pages. KernBHRS invites all residents of Kern County to participate in the Stakeholder Process inclusive of clients, peers, and family members. KernBHRS is also using the Behavioral Health Board and the Kern County Board of Supervisors to disseminate the Stakeholders invitations. During quarantine under COVID these meetings have switched to a sole virtual platform.

Kern has gathered input from Kern County Stakeholders that the California Early Psychosis Learning Health Care Network is desired and is needed to meet a gap for Early Psychosis services within the Mental Health Services System for the County. Below is a table of captured feedback from past stakeholder meetings that provide support for Early Psychosis Programming and entering the Learning Health Care Network Innovation Plan.

Date	Virtual Format	Stakeholder Comments & Support
September 8, 2021	Zoom	During the Stakeholder meeting on September 8, 2021, Dr. Christina Rajlal presented the EPI-Plus Learning Healthcare Collaborative to a group of 33 stakeholders. After the presentation, the platform was opened for comments or questions before asking the stakeholders to vote. Q&A: Question from Audience: Where would the funding be coming from for the EPI Plus Learning Healthcare Collaborative? Answer from Dr. Christina Rajlal: We do have money within the Innovation funds, but it does have to go through a very specific planning process to be able to utilize. Zoom Polling Question: Are you in support for using MHSA Innovation funding up to $1.5 million for the EPI-Plus Learning Healthcare Collaborative? Poll Question: Yes No Unsure



		Are you in support for using MHSA Innovation funding up to $1.5 million for the EPI-Plus Learning Healthcare Collaborative? 14 (80%) 0 (7%) 3 (13%) Polling Question Results: APPROVED (YES – 80%)
September 29, 2021	Zoom	During the Stakeholder meeting on September 29, 2021, Dr. Christina Rajlal presented the EPI-Plus Learning Healthcare Collaborative to a group of 24 stakeholders. After the presentation, the platform was opened for comments or questions before asking the stakeholders to vote. Q&A: Question from Audience: There were no questions from the audience. Zoom Polling Question: Are you in favor of the Innovation Plan- EPI -Plus Learning Healthcare Innovation Plan? Poll Question: Are you in support for using MHSA Innovation funding up to $1.5 million for the EPI-Plus Learning Healthcare Collaborative? Yes No Unsure 14 (82%) 0 (0%) 3 (18%) Polling Question Results: APPROVED (YES – 82%)

Total County Contribution to Collaborative Budget Request by Fiscal Year:

	TOTAL

Total County Contribution to Collaborative	*$510,981*

Total County Contribution to Collaborative Budget Request by Fiscal Year Budget Narrative for LHCN and Evaluation:
The budgeted detail above accounts for the buy-in for the LHCN and inclusive of the optional County-level data component. The County-level data component will additionally allow Kern County to focus on consumer level data relations to the program service utilization, crisis/ ED utilization, and psychiatric hospitalization and costs associated with these utilization domains.
The budget for the LHCN and evaluation if successful during time funded by Innovation can become sustainable by moving it to the Full-Service Partnership (FSP) programming under Community Services and Supports (CSS) funding stream. The population experiencing Early Psychosis is alignment with those needing a higher level of care as FSP serves.
BUDGET BY FISCAL YEAR AND SPECIFIC BUDGET CATEGORY FOR THE LHCN AND EVALUATION:

BUDGET BY FISCAL YEAR AND SPECIFIC BUDGET CATEGORY FOR LHCN AND EVALUATION							
EXPENDITURES							
PERSONNEL COSTS (salaries, wages, benefits)		**FY 21/22**	**FY 22/23**	**FY 23/24**	**FY 24/25**	**FY 25/26**	**TOTAL**
1	Salaries						-
2	Direct Costs						
3	Indirect Costs						
4	Total Personnel Costs	-	-	-	-	-	-
OPERATING COSTS		**FY 21/22**	**FY 22/23**	**FY 23/24**	**FY 24/25**	**FY 25/26**	**TOTAL**
5	Direct Costs						-
6	Indirect Costs						-
7	Total Operating Costs	-	-	-	-	-	-
NONRECURRING COSTS (equipment, technology)		**FY 21/22**	**FY 22/23**	**FY 23/24**	**FY 24/25**	**FY 25/26**	**TOTAL**
8							
9							
10	Total Non-recurring Costs						

CONSULTANT COSTS/ CONTRACTS (clinical training, facilitator, evaluation)		FY 21/22	FY 22/23	FY 23/24	FY 24/25	FY 25/26	TOTAL
11a.	Direct Costs	18,400	110,355	110,727	114,320	98,023	451,825
12	Indirect Costs	2,439	14,584	14,423	14,907	12,803	59,156
13	Total Consultant Costs	20,838	124,939	125,150	129,228	110,826	510,981
OTHER EXPENDITURES (please explain in budget narrative)		**FY 21/22**	**FY 22/23**	**FY 23/24**	**FY 24/25**	**FY 25/26**	**TOTAL**
14	Occupancy Costs						-
15							
16	Total Other Expenditures	-	-	-	-	-	-
BUDGET TOTALS:							
Personnel (line 1)		-	-	-	-	-	-
Direct Costs (add lines 2, 5 and 11 from above)		18,400	110,355	110,727	114,320	98,023	451,825
Indirect Costs (add lines 3, 6 and 12 from above)		2,439	14,584	14,423	14,907	12,803	59,156
Non-Recurring costs (line 10)							
Other expenditures (line 16)		-	-	-	-	-	-
TOTAL INNOVATION BUDGET		20,838	124,939	125,150	129,228	110,826	510,981

BUDGET BY FISCAL YEAR AND SPECIFIC BUDGET CATEGORY FOR COUNT SPECIFIC NEEDS:

BUDGET BY FISCAL YEAR AND SPECIFIC BUDGET CATEGORY FOR COUNTY SPECIFIC NEEDS							
EXPENDITURES							
PERSONNEL COSTS (salaries, wages, benefits)		**FY 21/22**	**FY 22/23**	**FY 23/24**	**FY 24/25**	**FY 25/26**	**TOTAL**
1	Salaries & Benefits	114,228	685,370	685,370	685,370	571,142	2,741,480
2	Direct Costs						
3	Indirect Costs						

4	Total Personnel Costs	114,228	685,370	685,370	685,370	571,142	2,741,480
OPERATING COSTS		**FY 21/22**	**FY 22/23**	**FY 23/24**	**FY 24/25**	**FY 25/26**	**TOTAL**
5	Direct Costs	2,033	11,700	9,200	9,367	8,500	40,800
6	Indirect Costs	20,977	125,861	125,861	125,861	104,884	503,444
7	Total Operating Costs	23,010	137,561	135,061	135,228	113,384	544,244
NONRECURRING COSTS (equipment, technology)		**FY 21/22**	**FY 22/23**	**FY 23/24**	**FY 24/25**	**FY 21/22**	**TOTAL**
8							
9							
10	Total Non-recurring Costs						
CONSULTANT COSTS/ CONTRACTS (clinical training, facilitator, evaluation)		**FY 21/22**	**FY 22/23**	**FY 23/24**	**FY 24/25**	**FY 21/22**	**TOTAL**
11a.	Direct Costs						
12	Indirect Costs						
13	Total Consultant Costs						
OTHER EXPENDITURES (please explain in budget narrative)		**FY 21/22**	**FY 22/23**	**FY 23/24**	**FY 24/25**	**FY 21/22**	**TOTAL**
14	Occupancy Costs	5,300	31,801	31,801	31,801	26,501	127,204
15							
16	Total Other Expenditures	5,300	31,801	31,801	31,801	26,501	127,204
BUDGET TOTALS:							
Personnel (line 1)		114,228	685,370	685,370	685,370	571,142	2,741,480
Direct Costs (add lines 2, 5 and 11 from above)		2,033	11,700	9,200	9,367	8,500	40,800
Indirect Costs (add lines 3, 6 and 12 from above)		20,977	125,861	125,861	125,861	104,884	503,444
Non-Recurring costs (line 10)							
Other expenditures (line 16)		5,300	31,801	31,801	31,801	26,501	127,204
TOTAL INNOVATION BUDGET		142,539	854,732	852,232	852,399	711,027	3,412,928

TOTAL BUDGET CONTEXT-EXPENDITURES BY FUNDING SOURCE AND FISCAL YEAR (FY)

TOTAL BUDGET CONTEXT- EXPENDITURES BY FUNDING SOURCE AND FISCAL YEAR (FY)							
ADMINISTRATION:							
A.	**Estimated total mental health expenditures for ADMINISTRATION for the entire duration of this INN**	**FY 21/22**	**FY 22/23**	**FY 23/24**	**FY 24/25**	**FY 25/26**	**TOTAL**

	Project by FY & the following funding sources:						
1	Innovative MHSA Funds	8,752	52,532	52,703	53,166	44,594	211,748
2	Federal Financial Participation	2,105	12,649	12,760	12,753	10,597	50,864
3	1991 Realignment						
4	Behavioral Health Subaccount						
5	EPI Plus Grant	12,559	75,263	74,820	74,849	62,497	299,988
6	**Total Proposed Administration**	23,416	140,445	140,284	140,768	117,688	562,600
EVALUATION:							
B.	**Estimated total mental health expenditures for EVALUATION for the entire duration of this INN Project by FY & the following funding sources:**	**FY 21/22**	**FY 22/23**	**FY 23/24**	**FY 24/25**	**FY 25/26**	**TOTAL**
1	Innovative MHSA Funds	18,400	110,355	110,727	114,320	98,023	451,825
2	Federal Financial Participation						-
3	1991 Realignment						
4	Behavioral Health Subaccount						
5	EPI Plus Grant						-
6	**Total Proposed Evaluation**	18,400	110,355	110,727	114,320	98,023	451,825
TOTAL:							
C.	**Estimated TOTAL mental health expenditures (this sum to total for funding requested) for the entire duration of this INN Project by FY & the following funding sources:**	**FY 21/22**	**FY 22/23**	**FY 23/24**	**FY 24/25**	**FY 25/26**	**TOTAL**
1	Innovative MHSA Funds	40,362	242,171	242,171	242,171	201,809	968,684
2	Federal Financial Participation	10,036	60,216	60,216	60,216	50,180	240,864
3	1991 Realignment						-
4	Behavioral Health Subaccount						**-**
5	EPI Plus Grant	71,164	426,484	423,984	424,151	354,153	1,699,936
6	**Total Proposed Expenditures**	121,562	728,871	726,371	726,538	606,143	2,909,484

Total Budget Narrative:
This total project to provide the CSC model & team incorporates 3 funding streams, including: Early Psychosis Intervention Plus (EPI-Plus) Grant, Federal Financial Participation (FFP/Medi-Cal) funding, and the proposed Learning Healthcare Network (LHCN) Innovation Funding. The entire project cost is $3,923,909.

For the evaluation component of the LHCN, the budget is $510,981 which is the county contribution to the collaborative. The operations of the program is budgeted at $3,412,928. The administrative cost over the 4 years of the program is $562,600. The total Innovation administrative cost is $211,748. Administration for evaluation is budgeted at $451,825 and is solely funded through Innovation.
The total operating budget for the CSC team is $2,909,484. Innovation operating expense is $968,684. The total requested funding for this Innovation project is $1,632,257.

Appendix IX: Ventura County

County Contact and Specific Dates

- Primary County Contact (Name, Email, Phone): Hilary Carson hilary.carson@ventura.org
- Date Proposal posted for 30-day Public Review: January 26, 2024-Febuary 26, 2024
- Date of Local MH Board hearing: February 26th 2024
- Date of BOS approval or calendared date to appear before BOS:

Description of the Local Need

Ventura County Power Over Prodromal Psychosis (VCPOP) is an early intervention program that conducts community outreach and education to community members about early warning signs of psychosis and provides a four-year intervention program with services and supports including psychiatric assessment, medication management, individual therapy, educational/vocational services, case management, multi-family groups, and peer skill-building groups. The program is now managed by the county and has more than doubled in size over the past two years. The current unduplicated number of clients being served in fiscal year 22-23 was 271. In 2021 it was just 116 clients and an increase of over 130%. It has been a challenge to increase staffing during the healthcare workforce crisis in order to meet the clinical demand. During this time of growth, the team has taken advantage of every statewide learning opportunity and uses an evidence-based outcome system.

One opportunity that has been employed is bi-weekly consultations from Dr. Barbara Walsh a national expert on early psychosis programs out of Maine. She noted a higher than usual rate of cases presenting to VCPOP with catalepsy. Catalepsy is a type of catatonia marked inactivity, decreased responsiveness to stimuli, and the tendency to maintain an immobile posture. Dr. Walsh has also noted that the team seems to be receiving more complex referrals than other counties, specifically, more dual-diagnoses and the onset of severe symptoms at a younger age. These observations have not been formally evaluated but seem to affirm the relative sense of the treating team.

As the program focuses on collaboration with families and does a good job of including family and other natural supports for the consumers, in turn, the need for additional services has also been observed. During the Community Program Planning Process for this proposed project, it was requested (more than once) to have more frequent parenting groups. Other services that have been in high demand are additional family therapy sessions, psychoeducational groups, and more in-home services.

Description of the Response to the Local Need

Joining the statewide collaborative means the VCPOP team would have local support from UC Davis team and other like counties in establishing and growing their programs. The outcome system that the learning collaborative utilizes is more streamlined and better for youth/young adults who may be too ill to respond to the existing lengthier system in place. The outcome system that will be implemented though the collaborative will also display current client progress rather than the annual evaluation that looks back on the previous year. This shift would allow the treatment team to make real-time decisions in collaboration with the client and their families.

With the proposed change to data collection and outcome system, Ventura County will be in a better position to evaluate staffing in relation to future growth in order to operate with greater fidelity to the best practice.

Cultural & Linguistic Competency

Ventura County's threshold language is Spanish and seventy-five percent of VCPOP clients identify as Hispanic/Latino. Whereas only seven percent of the VCPOP clients speak Spanish, a higher number of their families are monolingual Spanish. In addition, the county has a large group of Indigenous language speakers from Mexico that are not currently tracked with existing state demographic data. The VCPOP program works closely with the surrounding community's leveraging

religious institutions, Mixteco/Indigena Community Organizing Project which provides traditional healing interventions, and local schools. With more staff the ability to enhance these partnerships and even bring some of these services on site could increase.

Description of the Local Community Planning Process

The LCHN project has been discussed and listed as a potential Innovation program for the past two years in the Annual Update Fiscal Year 21-22 and 22-23 in the Three-year plan 23-26. More recently a short presentation was made to the Transitional Age Youth and the Youth and Family BHAB subcommittee meetings on the following dates:

October 11th, 2023
October 25th, 2023
December 20th, 2023

> *I am glad to hear about this program its very needed*
> *This sounds like a needed program*
> *No comment here, I am glad this is happening*
> *Do you know why our rates are so high? –Response was not definitive although there have been some theories.*
> *I hope there will be more parenting groups*
> *This is a very important program I would like more time to discuss (follow up presentation was scheduled)*
> *Will this program expand services into East County on par with what's happening in West County?*

Total Budget Request by Fiscal Year

Total budget by fiscal year for the county collaborative portion of the costs.

	FY 24/25	FY 25/26	FY 26/27	FY 27/28	TOTAL
Total County Contribution to Collaborative	$2,585,150.26	$2,723,647.78	$2,804,692.75	$2,888,574.35	$11,002,065.14

Budget Narrative for LHCN and Evaluation

The costs for the LHCN and Evaluation component of the project are described below. Unlike the initial counties who established the LHCN, the costs for Ventura county to join the project are not proportional based on the size of their county. Instead, the costs outlined below are based on the added expenses needed to cover activities for one additional program to join the LHCN. Therefore, the budget narrative is different from the one in the main proposal.

Personnel

The total personnel cost for the county portion of the evaluation and learning health care network component at UC Davis is $283,451 over 4 fiscal years. This includes $190,509 for salaries and $92,942 for benefits. Personnel will include:

- Tara Niendam, Ph.D. The PI of the project with part time effort for the duration of the project.
- Mark Savill, PhD. Dr. Savill is the qualitative and fidelity lead of the project and will have part-time effort for the duration of the project.
- Valerie Tryon, Ph.D. A program manager with part time effort for the duration of the project.
- Kathleen Nye, Development project manager with part time effort for the duration of the project.

•TBN, A part-time research assistant for all years for point person duties/project implementation support.
•TBN, A part-time research assistant for all years for to support fidelity evaluations and qualitative work.
•TBN, A part-time postdoctoral scholar to support academic research endeavors and dissemination of project findings.

The personnel costs include a 3% annual salary escalation for cost-of-living increases. Fringe benefits are calculated using UC Davis' federally negotiated rate agreement. Rates are applied by title code and fiscal year.

Supplies
The total cost for supplies will be $16,000. This will include project supplies handheld tablet devices for the Ventura County VCPOP program, including replacements (5 devices initially, 1 replacement per year over 4 years, $600 per device). Additional supply funds will cover software for project staff, stakeholder meeting costs, mobile hotspot subscription for the site, miscellaneous project supplies (copies, folders, etc.), and translation services.

Travel
Travel costs will total $2,600 over the course of the project. The majority of travel costs are for site visits to the program over 4 years.

Subcontracts
The project budgets for a subcontract with UCSF to lead the integrated county-level cost and utilization analysis in Ventura county. Subcontract costs will total $116,612. Their total cost is broken down into costs for personnel salaries, fringe benefits, travel, and supplies. Personnel include a co-investigator (Rachel Loewy, Ph.D.), a project manager, and a part-time clinical research coordinator.

An additional subcontract is budgeted for UCSD to perform the integrated county-level cost and utilization analysis in Ventura county. Subcontract costs will total $211,212. Their total cost is broken down into costs for personnel salaries, fringe benefits, travel, and supplies. Personnel include two co-investigators (Todd Gilmer, Ph.D.), a statistician, and part-time field researchers.

Consultation
The budget includes $4,800 for expert consultation, as needed. We will add additional funds Quorum Technologies for application development and support in Years 1-4. These costs to Quorum Technologies will include consultation to provide guidance in the development of the app's user interface to improve the consumer and provider experience with the app and will total $60,000 over the duration of the project.

Other Costs
Other costs will include subject and staff payments for taking surveys, participating in focus groups, and the advisory committee meeting. We have budgeted $4,000 for participant payments for these activities.

Indirect Costs
Indirect costs are calculated at the MHSOAC's published rate of 15% of Total Cost, totaling $65,445.

Total Cost
The total cost for the LHCN and Evaluation Budget from County INN funding will be $764,118.72.

Budget by Fiscal Year and Specific Budget Category for LHCN and Evaluation

BUDGET CONTEXT - EXPENDITURES BY FUNDING SOURCE AND FISCAL YEAR (FY)						
EXPENDITURES						
		7/1/24-6/30/25	**7/1/25-6/30/26**	**7/1/26-6/30/27**	**7/1/27-6/30/28**	**7/1/24-6/30/28**
PERSONNEL COSTS (salaries, wages, benefits)		**FY 20/21 (12 mo)**	**FY 21/22 (12 mo)**	**FY 22/23 (12 mo)**	**FY 23/24 (6 mo)**	**TOTAL**
1.	Salaries	$14,200	$57,042	$58,752	$60,515	$190,509
2.	Benefits	$7,364	$26,853	$28,502	$30,223	$92,942
3.	Indirect Costs	$3,805.41	$14,805.00	$15,397.76	$16,012.59	$50,021
4.	Total Personnel Costs	$25,369	$98,700	$102,652	$106,751	$333,472
OPERATING COSTS		**FY 20/21 (12 mo)**	**FY 21/22 (12 mo)**	**FY 22/23 (12 mo)**	**FY 23/24 (6 mo)**	**TOTAL**
5.	Direct Costs					
6.	Indirect Costs					
7.	Total Operating Costs					
NONRECURRING COSTS (equipment, technology)		**FY 20/21 (12 mo)**	**FY 21/22 (12 mo)**	**FY 22/23 (12 mo)**	**FY 23/24 (6 mo)**	**TOTAL**
8a.	Direct Costs (Supplies)	$8,050	$2,650	$2,650	$2,650	$16,000
8b.	Direct Costs (Travel)	$800	$500	$500	$800	$2,600
8c.	Direct Costs (Other Directs)	$1,000	$1,000	$1,000	$1,000	$4,000
9.	Indirect Costs	$1,738	$732	$732	$785	$3,988
10.	Total Operating Costs	$11,588	$4,882	$4,882	$5,235	$26,588
CONSULTANT COSTS/ CONTRACTS (clinical training, facilitator, evaluation)		**FY 20/21 (12 mo)**	**FY 21/22 (12 mo)**	**FY 22/23 (12 mo)**	**FY 23/24 (6 mo)**	**TOTAL**
11a.	Direct Costs (Subawards)	$55,630	$87,456	$90,690	$94,047	$327,823
11b.	Direct Costs (Consultants & App)	$31,200	$11,200	$11,200	$11,200	$64,800
12.	Indirect Costs	$5,505.88	$1,976.47	$1,976.47	$1,976.47	$11,435
13.	Total Subaward & Consultant Costs	$92,336	$100,633	$103,866	$107,224	$404,059
OTHER EXPENDITURES (please explain in budget narrative)		**FY 20/21 (12 mo)**	**FY 21/22 (12 mo)**	**FY 22/23 (12 mo)**	**FY 23/24 (6 mo)**	**TOTAL**
14.						

15.						
16.	Total Other Expenditures					

BUDGET TOTALS:					
Personnel (salaries and benefits)	$21,564	$83,895	$87,254	$90,738	$283,451
Direct Costs (consultation, nonrecurring costs)	$96,680	$102,806	$106,040	$109,697	$415,223
Indirect Costs (15% TC)	$11,050	$17,514	$18,107	$18,774	$65,444
TOTAL INNOVATION BUDGET	**$129,293**	**$204,215**	**$211,401**	**$219,210**	**$764,119**

Budget Narrative for County Specific Needs

Budget Narrative- Expanded Staffing for the Ventura County program for LHCN Participation
1 Registered Nurse-Mental Health
4 Behavioral Health Clinician IV
1 Mental Health Associate
3 Community Services Coord
1 Office Assistant IV
1 Behavioral Health Clinic Adm III
1 Peer Specialist III
1 Behavioral Health Manager
Total Salaries $5,686,815
Direct Costs $2,559,067 Benefits
Indirect Costs $1,236,882 At 15% of Salaries and Benefits
Total Personnel Costs $9,482,764
Total County Program Cost: $10,237,946.42

Budget by Fiscal Year and Specific Budget Category for County Specific needs

BUDGET BY FISCAL YEAR AND SPECIFIC BUDGET CATEGORY FOR COUNTY SPECIFIC NEEDS						
EXPENDITURES						
PERSONNEL COSTS (salaries, wages, benefits)		**FY 24/25**	**FY 25/26**	**FY 26/27**	**FY 27/28**	**TOTAL**
1	Salaries	1,339,510	1,406,485	1,448,680	1,492,140	5,686,815
2	Direct Costs	602,780	632,918	651,906	671,463	2,559,067
3	Indirect Costs	291,344	305,910	315,088	324,540	1,236,882
4	Total Personnel Costs	2,233,634	2,345,313	2,415,674	2,488,143	9,482,764
OPERATING COSTS		**FY 23/24**	**FY 24/25**	**FY 25/26**	**FY 26/27**	**TOTAL**
5	Direct Costs	98,455	101,408	104,451	107,584	411,897.76
6	Indirect Costs	14,768	15,211	15,668	16,138	61,784.66
7	Total Operating Costs	113,222.91	116,619.60	120,118.18	123,721.73	473,682.42

NONRECURRING COSTS (equipment, technology)		FY 24/25	FY 25/26	FY 26/27	FY 27/28	TOTAL
8	Tech Equipment (Computers and related accessories')	22,500				22,500.00
9	Furniture -& other Nonrecurring Cost	29,000				29,000.00
10	Total Non-recurring Costs	51,500.00	-	-	-	51,500.00
CONSULTANT COSTS/ CONTRACTS (clinical training, facilitator, evaluation)		**FY 24/25**	**FY 25/26**	**FY 26/27**	**FY 27/28**	**TOTAL**
11a.	Direct Costs	50,000.00	50,000.00	50,000.00	50,000.00	200,000.00
12	Indirect Costs	7,500.00	7,500.00	7,500.00	7,500.00	30,000.00
13	Total Consultant Costs	57,500.00	57,500.00	57,500.00	57,500.00	230,000.00
OTHER EXPENDITURES (please explain in budget narrative)		**FY 24/25**	**FY 25/26**	**FY 26/27**	**FY 27/28**	**TOTAL**
14						-
15						-
16	Total Other Expenditures	-	-	-	-	-
BUDGET TOTALS:						
Personnel (line 1)		1,339,510.00	1,406,485.00	1,448,680.00	1,492,140.00	5,686,815.00
Direct Costs (add lines 2, 5 and 11 from above)		751,234.70	784,326.34	806,356.60	829,047.11	3,170,964.76
Indirect Costs (add lines 3, 6 and 12 from above)		313,612.21	328,621.25	338,255.59	348,177.62	1,328,666.66
Non-Recurring costs (line 10)		51,500.00	-	-	-	51,500.00
Other expenditures (line 16)		-	-	-	-	-
TOTAL INNOVATION BUDGET		2,455,856.91	2,519,432.60	2,593,292.18	2,669,364.73	10,237,946.42

Budget Narrative for Total Budget Context – Expenditures by Funding Source and Fiscal Year

The county plans to use early intervention fundings to pay for this program after the conclusion of the INN program.

Total Budget Context – Expenditures by Funding Source and Fiscal Year (FY)

TOTAL BUDGET CONTEXT- EXPENDITURES BY FUNDING SOURCE AND FISCAL YEAR (FY)

ADMINISTRATION:						
A.	**Estimated total mental health expenditures for <u>ADMINISTRATION</u> for the entire duration of this INN Project by FY & the following funding sources:**	**FY 24/25**	**FY 25/26**	**FY 26/27**	**FY 27/28**	**TOTAL**
1	Innovative MHSA Funds	313,612.21	328,621.25	338,255.59	348,177.62	1,328,666.66
2	Federal Financial Participation					
3	1991 Realignment					
4	Behavioral Health Subaccount					
5	Other Funding					
6	**Total Proposed Administration**	313,612.21	328,621.25	338,255.59	348,177.62	1,328,666.66
EVALUATION:						
B.	**Estimated total mental health expenditures for EVALUATION for the entire duration of this INN Project by FY & the following funding sources:**	**FY 24/25**	**FY 25/26**	**FY 26/27**	**FY 27/28**	**TOTAL**
1	Innovative MHSA Funds	129,293.35	204,215.18	211,400.56	219,209.62	764,118.72
2	Federal Financial Participation					
3	1991 Realignment					
4	Behavioral Health Subaccount					
5	Other Funding					
6	**Total Proposed Evaluation**	129,293.35	204,215.18	211,400.56	219,209.62	764,118.72
TOTAL:						
C.	**Estimated TOTAL mental health expenditures**	**FY 24/25**	**FY 25/26**	**FY 26/27**	**FY 27/28**	**TOTAL**
1	Innovative MHSA Funds	2,378,489.74	2,510,787.45	2,585,446.61	2,662,750.83	10,137,474.63
2	Federal Financial Participation	$ 195,496.09	$ 201,360.97	$ 207,401.80	$ 213,623.85	817,882.71
3	1991 Realignment					-
4	Behavioral Health Subaccount					-
5	Other Funding	$ 11,164.43	$ 11,499.36	$ 11,844.34	$ 12,199.67	$46,707.80
6	**Total Proposed Expenditures**	**$2,585,150.26**	**$ 2,723,647.78**	**$ 2,804,692.75**	**$ 2,888,574.35**	$11,002,065.14

Appendix X: Letters of Support

Zima Creason, Mental Health America

October 11, 2018

Tara Niendam Ph.D.
Associate Professor of Psychiatry
Executive Director, EDAPT and SacEDAPT Clinics
University of California at Davis
4701 X Street, Suite E
Sacramento, CA 95817

Dear Dr. Niendam:

I am sending this letter to indicate the support of Mental Health America of California for your proposed California Collaborative Learning Health Care Network (LHCN) project. Our organization will serve as an important stakeholder for feedback as we have valuable insight and experience regarding the target population, i.e. those experiencing early affective and/or nonaffective psychosis. Our involvement in this statewide collaborative will support identification of other important stakeholders, e.g. community members, family members, and mental health consumers for study related focus groups to advance the learning health care goals of measurement-based treatment, continuous improvement and innovation in care delivery, and practice-based research to drive the process of scientific discovery.

Sincerely,

Zima Creason
President & CEO
Mental Health America of California

www.mhac.org

2110 K Street • Sacramento, CA 95816-4921 • T: (916) 557-1167 • F: (916) 836-3225

Bonita Hotz, Stakeholder

October 12, 2018

Subject: Letter of Support

To Whom It May Concern,

As a parent served by the EDAPT program 2008-10, I want to offer my whole-hearted support for the proposed *Early Psychosis Learning Health Care Network Statewide Collaborative* project.

When our daughter Rachel began her frightening descent into psychosis at the age of 14, my husband and I didn't know where to turn. After nearly two years of searching for a treatment provider who could help, and repeatedly being disappointed, we were fortunate to find the EDAPT program in time to pull our daughter back from the disastrous path she was on. I know from that personal experience what a tremendous difference coordinated specialty care can make, even as it was back then in its early stages. Besides the variety of services, including supported education to help keep Rachel in school, occupational therapy and parent support groups, we reaped the benefits of the wealth of information UC Davis had in the field, from its research efforts as well as collaboration with other similar programs and universities across the country.

While in EDAPT, Rachel also was able to participate in some of this research, including a mobile application project to collect and deliver to her provider real-time data on her day-to-day wellness. This experience not only gave her treatment team the ability to monitor her more closely, and intervene when needed, but provided her with the insight needed to manage her illness more effectively each day. I spoke with her just today about this letter of support, and she wanted me to tell you that she still benefits from the mindfulness skills she learned while a participant in that project.

My family's experience with EDAPT inspired me to work as the Family Advocate for the SacEDAPT program after I retired from my career with the State of CA in 2014. Over four years, I worked with over 200 families from all walks of life and circumstances, but with the shared experience of a loved one with psychosis. I can tell you from that experience that this program works, and I'm excited and encouraged by this proposal to collect and share outcome data with other similar programs across our State so that they can support clients and their families even better.

I attended a lecture recently, sponsored by the Behavioral Health Center of Excellence (itself a collaborative effort to raise awareness of mental health issues), and was stunned to learn more about the tremendous cost to society of not effectively treating mental illness in our young people. It's a crisis that we're only beginning to address. We desperately need these efforts to enable providers to work together to improve treatment, and therefore outcomes. Let's not forget that these "outcomes" are our children. And they are worth the investment of innovative programs like the proposed *Learning Health Care Network*.

Sincerely, and with gratitude for the chance to voice my support,

Bonita Hotz
Bhotz001@gmail.com
(916) 798-7642

Sonya Gabrielian, MD, Consultant, UCLA

UNIVERSITY OF CALIFORNIA, LOS ANGELES | UCLA

BERKELEY • DAVIS • IRVINE • LOS ANGELES • RIVERSIDE • SAN DIEGO • SAN FRANCISCO

SANTA BARBARA • SANTA CRUZ

Sonya Gabrielian, MD, MPH
UCLA Department of Psychiatry and Biobehavioral Sciences
VA Greater Los Angeles
11301 Wilshire Blvd., Bldg 210A
Los Angeles, CA 90073

October 9, 2018

Tara Niendam Ph.D.
Associate Professor of Psychiatry
Executive Director, EDAPT and SacEDAPT Clinics
University of California at Davis
4701 X Street, Suite E
Sacramento, CA 95817

Dear Dr. Niendam:

I am sending this letter to indicate my support of your to create the California Collaborative Learning Health Care Network (LHCN). I will serve as an important consultant for development and implementation of measures related to homelessness and risk factors associated with homelessness. I have valuable insight and experience regarding measurement of homelessness in the target population, i.e. those experiencing early affective and/or nonaffective psychosis. Appropriate measurement of risk factors for homelessness is critical for primary prevention of this important outcome. My involvement in this statewide collaborative will advance the learning health care goals of measurement-based treatment, continuous improvement and innovation in care delivery, and practice-based research to drive the process of scientific discovery.

Within this role, I am prepared to dedicate the time needed to consult on the range of outcome measures proposed in the study. I will participate in regular conference calls related to design, implementation, data analysis and interpretation, and development of reports and papers. I will also participate in an annual meeting at UC Davis to review progress on the grant. I have allocated 50 hours over the course of the grant for this role.

Sincerely,

Sonya Gabrielian, MD, MPH
Assistant Professor, Department of Psychiatry and Biobehavioral Sciences

Binda Mangat, Service Contractor

October 12, 2018

Tara Niendam Ph.D.
Associate Professor of Psychiatry
Executive Director, EDAPT and SacEDAPT Clinics
University of California at Davis
4701 X Street, Suite E
Sacramento, CA 95817

RE: Project Proposal by Tara Niendam MHSA INN County Collaborative for EP Learning Healthcare Network

Dear Dr. Niendam:

Quorum Technologies and its affiliate, [x]cube LABS , are pleased to submit this letter in support of the 5-county collaborative MHSA INN project submission to build an EP Learning Healthcare Network for California.

Located in Sacramento, CA, Quorum Technologies was founded by experienced healthcare IT executives who saw the unique opportunity that mobile technology and healthcare informatics provides in healthcare, and developed an ownership partnership interest with [x]cube LABS to provide a complete package of knowledge and skills necessary to meet the needs of the mobile health market.

We enthusiastically share UC Davis Health System's vision for using advanced technology to improve healthcare and simultaneously lower costs. Dr. Niendam's proposal to utilize mHealth technology to measure and improve outcomes in early psychosis care has great potential to meet the proposed goal of the RFP. Furthermore, the target patient population is particularly well suited towards using technology as part of their daily living, which will further increase the chances of this project succeeding. We have worked with Drs. Niendam and Tully since 2014 and developed two applications that have been successfully been deployed on both research and community settings. In the prior NIMH funded R01 for Dr. Cameron Carter, we developed an application to support screening for psychosis in community settings to reduce the duration of untreated psychosis. This app has been successfully implemented in 30 community mental health, school, psychiatric crisis and primary sites across Sacramento County. With the support of UC Davis Behavioral Health Center of Excellence, we developed MOBI to enhance the client-provider relationship in early psychosis care. We are excited to use this funding to enhance MOBI and support outcomes data collection and visualization in EP care across the state of California.

With a keen awareness of the strategy behind this project, Quorum and [x]cube Labs would follow a 2-phase process to address the flow and logic of the App and the look and feel of the web-based User Interface.

2485 Natomas Park Drive, Suite 320 ◊ Sacramento, CA 95833 ◊ 916.669.5577 ◊ www.quorumtech.net

PHASE 1: STRATEGY

PHASE 1 – Activities

Project Specification Document
Top-Level App Design
Identify Architecture goal for the App
Review and Incorporate the Architectural practices at UC Davis
Identify all data sources and dependencies – Internal/External

PHASE 1 – Deliverables

Detailed Specification Document
Architectural Goals in Alignment with the Existing System
Top-level App Design
Technical Architecture
Wireframe

PHASE 2: ENGINEERING

PHASE 2 – Activities

Project Plan
Development
Testing
Submission
Full Effort estimation

PHASE 2 – Deliverables

Detailed Project Plan
App & Platform Builds
Final Build, QA, Test and App sign off

We would be happy to develop this app for a cost that will not exceed $ 1,046,557, and look forward to a continued and meaningful partnership with UC Davis Health System.

Sincerely,
Binda Mangat
Binda Mangat
President & Chief Executive Officer
Quorum Technologies, Inc.

Brandon Staglin, One Mind

October 1, 2018

Tara Niendam Ph.D.
Associate Professor of Psychiatry
Executive Director, EDAPT and SacEDAPT Clinics
University of California at Davis
4701 X Street, Suite E
Sacramento, CA 95817

Dear Dr. Niendam –

I am sending this letter to indicate One Mind's commitment to provide $150,000 dollars to the California Collaborative Learning Health Care Network (LHCN) project with potential under review to provide an additional $1,350,000 by Fiscal Year 2024. Further, our organization will serve as an important stakeholder for feedback as we have valuable insight and experience regarding the target population, i.e. those experiencing early affective and/or nonaffective psychosis. Our involvement in this statewide collaborative will support identification of other important stakeholders, e.g. community members, family members, and mental health consumers for study related focus groups to advance the learning health care goals of measurement-based treatment, continuous improvement and innovation in care delivery, and practice-based research to drive the process of scientific discovery.

Sincerely,

Brandon Staglin
President
One Mind

P.O. Box 680, Rutherford CA | 707.963.4038 | www.onemind.org

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